Caring and Transformation in Oncology Nursing
Administration: Paradigms of Leadership

by

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Dedication

This accomplishment is dedicated to

Marilyn and Joseph Young,

my parents and the people who allowed me to believe that I could be and do whatever I set my mind to.
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Abstract

CARING AND TRANSFORMATION IN ONCOLOGY NURSING ADMINISTRATION: PARADIGMS LEADERSHIP

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Dissertation Director: Dr. Rita L. Ailinger

Caring has a history of being central to nursing and has long been held to be an essential component of the clinical practice of nurses involved in direct patient care activities. While nurse administrators have been recognized for their transformational leadership capabilities, less attention has been given to caring in the practice of nursing administration leadership or the effects of this leadership as experienced by their subordinates. The parallels found between transformational leadership behaviors and human caring factors provided the foundation for this study. The purpose of this study was to generate an understanding of the structure and experience of caring as a component of the leadership practice of nurse administrators. Multiple triangulation was used to investigate the phenomenon of caring as it is experienced by...
nurse administrators and in turn experienced by their subordinates. Nurse administrators of oncology services in large, acute care facilities were interviewed to describe their leadership and the place of caring in that leadership practice. Subordinates from each facility were asked to rate their perceptions of nurse manager caring behavior. Nurse administrator interviews underwent dual content analysis using Watson's Theory of Human Care and Burns' Transformational Leadership Theory.

Three themes emerged from the data: 1.) A person centered value system rooted in the reality of clinical practice; 2.) Courage and sensitivity in decision making; and 3.) The intentional cascading effect of caring leadership. These themes were found present in each interview and were the result of recurring patterns of transformational leadership behaviors and human caring factors. In each administrator–subordinate group pair the ratings of manager caring behaviors supported the cascading effect of caring leadership; that is staff reported feeling cared for by the manager but to a lesser degree than the administrator self report of her own caring behaviors.

Results suggest the initial identification of nurse administrator transformational leadership behaviors and caring attributes which are linked with subordinate perceptions of administrator caring. These behaviors and attributes extend the body of knowledge related to transformational leadership
and caring theory. This new knowledge can support nurse administrators in devoting deliberative efforts toward caring leadership and the outcomes of that caring.
What is essential in human existence is that the human has transcended nature—yet remains a part of it. The human can go forward, through the use of the mind, to higher levels of consciousness, by finding the meaning and harmony in existence.

Watson (1988, p. 45)
Introduction

How do nurse administrators serve as leaders? Do these nurse administrators experience caring in their leadership practice, and if so how? This dissertation examines the phenomena of caring and transformational leadership as they are experienced by nurse administrators. Nursing administrators of oncology services were chosen to participate in this exploration of the meaning and harmony of their leadership practices. No previous inquiries have been reported into the duality of caring and transformational leadership within the practice of the nurse administrator.

The complexity of exploring both caring practices and transformational leadership resulted in the selection of multiple strategies for this inquiry. Using a triangulated research process, both qualitative data from administrator interviews, and quantitative data from staff subordinates were obtained to allow for a wholeness in the final perspective.
Background and Significance of Study

The nurse executive has the ongoing challenge of integrating the domains of human care and economics within the context of the healthcare organization. It has been proposed that the unique challenge for nurse executives is the integration of human care and economics into a system that supports both the goals of patient care and organization survival (Nyberg, 1990). The nurse administrator may be the link between those two seemingly opposing goals. The leadership provided by the nurse administrator sets the values and tone for the provision of nursing care to the patient. However, there is very little knowledge about human caring in nurse administrator practice and even less about leadership styles which promote this caring.

The administrator's integration of knowledge of nursing with that of administration can contribute to the building of "strong, comprehensive theories that address the needs of people who receive nursing services" (Anderson, 1989, p. 23). Indeed, if nursing administration is to continue to develop its unique identity within the discipline, it must strive to form a knowledge base which supports this contention. In a similar perspective, nurse administrators also have the challenge of describing those components of practice which differentiate it from management and business
theory. As a result of years of research and theory development, nurses in clinical practice no longer identify that practice as a synthesis of the disciplines of medicine, psychology, social work and others. Nurses in administration must strive for similar gains in understanding that their practice is more than and different from a synthesis of knowledge of the disciplines of human resource and business management, economics and organizational development.

Understanding the distinctive knowledge found within nursing administration will contribute to identification of effective practices which allow nurse leaders to continue to balance human care and economics. This knowledge is essential for the combined future goals of provision of patient care, organization survival and sustained caring in nursing practice.

Purpose

In view of the lack of specific knowledge about caring and leadership in the practice of nursing administration, the overall purpose of this study was to generate an understanding and structure of the experience of caring as a component of the leadership practice of nurse administrators.
Objectives

Derived from the overall purpose, specific objectives were developed to generate the structure of caring as a component of the leadership practice of nurse administrators:

1. to describe the perceptions of nurse administrators of cancer services regarding their experiences of caring within their leadership practice,

2. to uncover common elements and themes of caring and transformational leadership in the practice of nurse administrators of cancer services,

3. to describe the effects of caring in nursing administration as experienced by staff nurse subordinates of nurse administrators of cancer services.

Caring: Central to Nursing Practice

Caring has a long history of being central to nursing practice as that practice has been defined by nurse-patient interaction (Boykin & Schoenhofer, 1990). Caring is emerging as a significant concept for nursing and has been investigated in the clinical practice, education and research of nurses (Morse, Bottorff, Neander, & Solberg, 1991). Little attention, however, has been given to caring in the practice of nurse administrators or the effects felt
by subordinates. However, as Schaefer (1991) has stated, 
"The growing interest in defining the caring work of nurses 
gives evidence that caring is not limited to the nurse- 
patient relationship" (p. 275).

Three theorists have presented definitions of caring 
which may have applicability in the work of the nurse 
administrator. Mayeroff (1971) discussed caring as a means 
of helping another to grow and actualize. Certainly an 
important goal of nurse executives is the growth and 
actualization of staff. Does caring by the nurse 
administrator facilitate this growth and actualization 
process for the staff nurse?

Watson (1988) calls caring the moral ideal of nursing 
with a goal of protection, preservation and enhancement of 
human dignity. She identifies characteristic behaviors, 
called caring factors, which are expressions of nurse 
caring. Can these behaviors be identified in the leadership 
practice of nurse administrators?

Leininger (1988) identifies caring as processes, 
decisions or activities which are skillful and nurturing and 
are directed toward assisting people. She further states 
that the assistance is reflective of behavioral attitudes 
which are succorant, empathetic, supportive, protective, 
compassionate and others dependent on the needs of those 
being assisted. Do nurse administrators incorporate these
behavioral attitudes into their practice? Chapter II develops the conceptual application of caring to nursing administration practice.

Leadership

Research and literature on leadership has increasingly focused on the model proposed by Burns in 1978. In his model, Burns presents two basic types of leadership: transactional and transformational. In transactional leadership, the leader approaches the follower with an intention of exchanging one thing for another. Burns uses the examples of jobs exchanged for votes and subsidies for campaign contributions (1978, p. 4). Transformational leadership, in addition to looking at the demands and needs which currently exist for the potential follower, seeks to satisfy higher needs and unite with the deeply held values of the followers (Dunham & Klafhen, 1990). Through transformational leadership, leader and follower join with one another to achieve higher levels of motivation and morality. Burns (1978) describes moral leadership as the highest level of transformational leadership which relates leadership behavior to explicit, conscious values (p. 46).

Nurse administrators have described the perception that they function in ways that are different from non-nurse administrator colleagues. In a national study of nurse administrators, data revealed that those administrators with
a graduate degree in nursing were more transformational in their leadership style than those with graduate degrees in other disciplines (Dunham & Klafhen, 1990). The same research also found that when comparing data with that obtained in a 1985 study of managers, administrators and world leaders, the nurse administrators' transformational scores were higher than those achieved in the 1985 study.

Meighan (1990) reported the results of research examining important characteristics of nurse leaders. Staff nurse respondents identified many characteristics consistent with transformational leadership behavior. In addition, over seventy percent (70%) of the respondents selected caring as being among the most important traits of nurse leaders.

The evidence from these studies when combined with the anecdotal reports of nurse administrators led this investigator to a query which culminated in this investigation: If nurse administrators are more transformational in their leadership than other leaders, what are the defining, contributing factors of this difference? Is caring a component of these differences? The relationship between caring and transformational leadership merits further discussion.
Caring and Leadership

Watson's (1988) Human Caring Theory and Burns' (1978) Transformational Leadership / Moral Leadership theory have many shared concepts. The possible relationship between these theories has not been explored, although studies have shown nurse executives to consistently rank higher as transformational leaders than any other group of executives (Dunham & Klafhen, 1990). Burns (1978) describes moral leadership as a relationship between the leader and the led based not only on power, but also on mutuality of needs, aspirations and values; moral leaders take responsibility for their commitments and assume leadership in bringing about change that has been agreed to. He asserts that moral leadership always "emerges from and returns to, the fundamental wants and needs, aspirations and values of the followers...leadership that can produce the kind of social change that will satisfy followers' authentic needs" (1978, p. 4). Burns describes leadership and power not as things, but as relationships. He states that the "...most powerful influences consist of deeply human relationships in which two or more persons engage with one another" (1978, p.11).

These ideas parallel Watson's Theory of Human Care. Watson asserts that human care and caring are the moral ideal of nursing, the end of which is protection, preservation and enhancement of human dignity (1988, p. 29).
In addition, she states that the goal of nursing "is to help persons gain a higher degree of harmony within the mind, body and soul which generates self-knowledge, self-reverence, self-healing, and self-care processes..." (1988, p. 49). Watson goes on to describe ten caring factors (interventions in the human care process) which are similar to the attributes of transformational or moral leadership. These include a humanistic system of values, sensitivity to self and others, creative problem-solving, and transpersonal teaching and learning. Like Burns, Watson speaks of the power of relationships in caring. As the led must first acknowledge the leader for her to be effective, so must the recipient of caring acknowledge the presence of the nurse. "It is not so much the what of the nursing acts, or even the caring transaction per se, it is the how (the relation between the what and the how), the transpersonal nature and presence of the union of two persons' soul(s), that allow for some unknowns to emerge from the caring itself" (Watson, 1988, p. 71).

According to Burns (1978), transformational leadership that is moral implies influencing change consistent with the ethical principles of one's society or profession. If caring is the moral ideal of nursing, then the transformational nurse leader has the obligation to influence change within the organization that is consistent
with and promotes caring. There is a significant lack of knowledge about how nurse administrators acknowledge this obligation, or whether they can describe how caring is actualized in their leadership practice. Neither is there information about the subordinates of the administrator and the felt effects of caring leadership in their work environment.

If the body of knowledge which pertains to the work of nurse administrators can be developed to describe and demonstrate the presence of caring, then the practice and education of nursing administration can begin to devote deliberative efforts toward caring leadership, and the outcomes of this caring. Nyberg (1989) in a discussion of the element of caring in nursing administration summarized this point: "The nurse administrator can exemplify caring and thus enrich the patient care environment by insisting on the development of an emphasis on caring behaviors throughout the nursing division" (p. 11).

Summary

As an experienced nursing administrator who has experienced the enigma of this caring component of leadership, I have been challenged to illuminate the hidden components of nurse administrator practice. The overall purpose of this study was to generate
an understanding and structure of the experience of caring as a component of the leadership practice of nurse administrators. Qualitative and quantitative methodologies were utilized to explore the leadership practices of nurse administrators of cancer centers and the perceived effects on staff subordinates.

Chapter II introduces a review of the literature relevant to the purpose and objectives of this study. Chapter III presents the methods utilized and expands the description of triangulation as applied in this investigation. Chapter IV presents the analysis and interpretation of study findings. Finally, Chapter V presents a summary of the conclusions of the study, reviews study limitations and discusses recommendations and implications for the study and practice of nursing administration.
CHAPTER II

Society needs the caring professions, and nursing in particular, to help to restore humanity and nourish the human soul in an age of technology....

Watson (1988, p. 49)
Literature Review

The literature review contained in this chapter is intended to provide the context within which this dissertation was conceptualized, evolved, and completed. Therefore this chapter serves as a lens through which the reader may view the phenomena of caring and leadership as they are experienced by nurse administrators. This lens is a result of the explication, synthesis and conclusions drawn from previous research and scholarship in the areas of caring and leadership. As noted, the practice base of nursing administration is at present largely a result of the blending of knowledge from clinical nursing practice and management theories. Therefore, the literature reviewed for this dissertation was drawn from nursing research and the administration and leadership disciplines.

Caring has been generally characterized as a way of being in a relationship and is often viewed as an inherently feminine attribute. Gilligan provides an instructive view of the ideal of care as "...an activity of relationship, of seeing and responding to need, taking care of the world by sustaining a web of connection so that no one is left alone"
The conceptualization of a web is presented as a uniquely feminine viewpoint on relationships. This perspective is contrasted to a hierarchical, male viewpoint of relationships. The juxtaposition of these two perspectives, web and hierarchy, provides an excellent metaphor for the literature categories related to leadership and caring. Indeed, the nursing literature related to caring most frequently describes relationships among people within the web perspective, while leadership literature is more often a depiction of the hierarchical nature of relationships between leaders and followers.

The literature related to caring and nursing was predominately devoted to the clinical practice perspective. Additional views of caring were presented as theoretical frameworks for clinical practice. Fewer writers explored caring from the perspective of nursing administration.

Leadership was represented in the literature of both business administration and nursing. Specifically, business administration literature focused on transformational leadership, looking at leaders, followers, and their behaviors. Leadership within nursing administration also examined concepts related to transformational leadership. These categories provide the framework for organizing the literature review and this chapter. Caring in nursing, both in traditional clinical and other contexts, is reviewed.
This is followed by a review of transformational leadership, the relationship between leaders and followers, and leadership in nursing administration. Finally, the linkages between transformational leadership and caring are explored.

Background

The study of nursing administration must necessarily be conducted within the framework or circumstances of the healthcare delivery system. This system is widely acknowledged to be in a state of fluctuation, transition and evolution with unknown outcomes. The place of nursing within this healthcare environment is similarly on an unpredictable course. Darbyshire (1993) sounded an admonition in which he asked what nurses could do to preserve caring in destitute times. The transitory state of healthcare was characterized as a time of destitution due to a "...growing nihilism and an increasing reliance on a technical understanding..." which pervades every aspect of the system (1993, p. 507). The danger for nursing, as described by Darbyshire, is that it will adapt to these changes and in doing so, lose its moral vision of caring. The challenge for nurses is to resist the urge to adapt and instead to actively transform the healthcare system into one which is focused on caring and healing. Achievement of such a grand task will reside largely in the practice domains of nurse administrators who serve as leaders for clinicians.
The challenge of retaining caring within the practice of nursing was also explored by Harrison (1990). This viewpoint focused on the difficulty of maintaining caring as a universal value which guides nursing practice. The particular point of concern raised is one which has great relevance for nurse administrators: if nurses are to be caring in their relationships with patients, they must also feel cared for and about in their work environment. The work of the nurse administrator centers on providing environments and supports for the delivery of patient care. What leadership attributes and behaviors are required of nurse administrators which will enable nurses to care? The question remains unanswered.

The jeopardy to caring in nursing has been specifically related to increasing competition and corporatization within healthcare (MacPherson, 1989). The "big-business" and profit focus often found in today's healthcare institutions are seen as being at odds with nursing's human caring ethic. Since the 1960's the gradual restructuring of the healthcare system has resulted in an increased focus on competition. The restructuring has moved from evolutionary to revolutionary, and the focus on competition has taken a much harder edge. Prospective payment, capitation and other financial pressures have caused institutions to take an increasingly administrative focus on cost reduction. This
focus has resulted in an emphasis on productivity and technology to control costs at the expense of the nurse-patient relationship. As previously discussed, the cost emphasis is seen as being at odds with and jeopardizing the caring ethic of nursing. The nurse administrators within the healthcare system must develop strategies for making caring possible within the corporate context. Achievement of this outcome will require an understanding of leadership and caring within the practice of these nurse administrators.

Caring and Nursing

Caring has been identified as the focal point of nursing practice since the inception of the profession. From Nightingale's Notes on Nursing in 1859, through Peplau's 1952 advocation of nurses' therapeutic use of self, to contemporary theorists, in one form or another, nursing has been associated with care and caring. The caring focus, although widely accepted, has been subjected to earnest scientific investigation only over the past fifteen years. The infancy stages of these explorations of a caring heritage leave the nursing profession with the irony of a greater awareness of what is not known about care and caring. This literature review will present a synthesis of the many perspectives on caring and nursing.
Caring Conceptualizations

The nursing literature contains no fewer than twenty-five distinct conceptualizations of caring. The individual review of each is less informative than a synthesis of the major themes and differences found among them. Morse, Bottorf, Neander, & Solberg (1991), identified the schizophrenia of a profession which has accepted multiple concepts of caring as its ideal without discerning the outcomes and utility of such an ideal. The resulting dilemma led Morse et al. (1991) to develop a framework for viewing the many images of caring. This framework (Morse et al., 1991) serves as the organizing structure for a review of caring in nursing. The literature review focuses on the clinical conceptualizations of caring as they form the preponderate works in this body of knowledge. The relationships of the clinical perspective to the practice of nursing administration will be addressed.

Leininger called caring "the essence of nursing and the central, dominant and unifying feature of nursing" (1988, p.152). This honorable description of the work of a profession is at once encompassing and vague. It presents questions for the reader such as "What is the intention of nurse caring?", "Is caring a virtue, a characteristic, a set of learned behaviors, or an amalgam of all three?" "What are the outcomes of this caring, who or what is served?"
The development of thoughtful responses to these questions will assist in a more clear understanding of the phenomenon.

The intention of nurses caring for patients has been portrayed as both constant and changing. Those authors with the view of an unvarying intent of caring present the argument that caring is a moral ideal that extends beyond the specifics of particular patient situations (Watson, 1988; Leininger, 1988; Fry, 1989). This perspective recognizes the reality of variation in the forms that nurse caring may take due to situational factors, such as the place or time of nurse-patient interaction, but maintains that the intent remains constant. Those authors taking the position that the caring intent of nurses varies, include Ray (1989), who asserts that caring is a concept very much defined by its context. This context may be modified by political, economic, social, physical, and legal structures resulting in a kaleidoscope of caring intent. The summary of these authors is agreement that variation occurs in caring, whether in the intent of caring or the form of the caring. Development of measures of caring, its places of occurrence and its outcomes will assist in clarifying this dilemma.

The pattern or composition of nurse caring presents another arena for divergent viewpoints. The fundamental question is asked "Can nursing be defined by a set of tasks
or behaviors?" Those authors proposing caring as a therapeutic intervention are clear in the perspective that nurse caring can be defined by verbal, non-verbal, and technical acts or behaviors (Orem, 1985; Larson, 1984; Swanson-Kauffman, 1988). Another perspective maintains that caring provides the foundation from which the nurse draws conclusions, makes decisions, and takes actions. This foundation, while influencing behaviors, cannot be reduced to a set of behaviors (Benner & Wrubel, 1989; Fry, 1989; Watson, 1988). However, even within the perspective of caring as a moral foundation, there resides the challenge of operationalizing this foundation, taking the abstract ideal and making it real. The identification of behavioral outcomes is an essential prerequisite to claiming the continued value of nurse caring.

The outcome of nurse caring has been primarily focused on the effects felt by the nurse and the patient. The most clearly defined outcomes are related to patients as the recipients of nurse caring. The patient outcomes identified include healing and health, personal growth and self actualization, coping, comfort, safety, well-being, and protection of humanity (Orem, 1985; Larson, 1984; Watson, 1988; Leininger, 1988). Ray, (1988) identified a rather unique outcome of caring within the context of an organization. This outcome is organizational development.
which promotes purposeful caring goals which would affect nurses, patients and the organization. Several authors have proposed that the nurse experiences beneficial outcomes from caring for patients. These outcomes include personal enrichment, ethical behavior and satisfaction (Fry, 1989; Benner & Wrubel, 1989). Finally, some authors view the outcomes of caring as benefitting both patient and nurse. This view promotes caring as a reciprocal phenomenon mutually experienced by the nurse and the one cared for. Through this reciprocity the nurse and the patient experience fulfillment, spiritual growth, self-knowledge and self-healing (Watson, 1968, Gadow, 1985).

In summary, caring has been viewed as an interpersonal interaction, a therapeutic intervention, an affect, a human trait, and a moral imperative. Nurse caring may be variable in intent or the intent may be constant but take many forms. Caring may provide the foundation from which the nurse approaches the practice of nursing, but its essential components and forms must become clearly identified. And finally, the outcomes of this phenomenon must be explicated and related to the products of healthcare.

With the exception of the work by Ray (1988), these conceptualizations of caring refer to the clinical context of nursing practice. However, the same issues may be transferred to nursing administration. Nurse administrators
are deeply concerned about their ability to articulate and defend the caring tradition of nursing practice. Nurse administrators are similarly concerned about their abilities to promote and sustain a culture that values caring. The issues of intent, foundations, component forms and outcomes of caring, though not fully developed in clinical nursing practice, are less well understood in the practice of nursing administration. However, since nurse administrators are the designated formal leaders of nursing in healthcare organizations, resolution of these issues has become more crucial for the administrators.

Caring in Different Nursing Contexts

Caring has been related to contexts which extend beyond the basic nurse-patient relationship, although these extensions are few in number. The perspective of nursing and caring within the context of the corporation was proposed by MacPherson (1989). Placing nurse caring within the seemingly cold world of corporations is viewed as necessary for the development of a supportive social context within which health care is delivered. The notion of corporation is frequently associated with industry, profits, losses and competition but almost never with caring.

MacPherson contends that nurse administrators are obligated to bridge the divergence between corporate profits and a caring ethic through values clarification. Failure to
do so will perpetuate an environment that increasingly curtails nurses' opportunities implement an ethic of care. While this seems a worthy mission for nurse administrators, MacPherson offers no specific strategies.

Nyberg has contributed the most extensive writing on the subject of caring in nursing administration. In 1989, Nyberg proposed that displaying and exemplifying caring behaviors in interactions with others - through meetings, conversations, and other interactions - nurse administrators could establish a norm of sensitive caring which would emerge within the institution. "As employees see and feel expressions of caring, the attitudes of caring are reproduced in patient situations" (1989, p. 9). The attribute of sensitivity to others was also identified by Noddings' description of the caregiver as engrossed in and able to experience the pleasure or pain recounted by the cared-for person; the caregiver communicates interest, concern and delight in the one cared-for (1984, p. 16-19). Nyberg identified as conducive to caring commitment, self-worth, ability to prioritize, openness and the ability to bring out potential. These attributes were not derived from research or theory, but from the experience of the author.

In 1990, Nyberg presented an expansion of the concept of caring in nursing administration in a theoretical model which included organizational, nursing, and economic theory,
philosophy, and human care. She intended the theory to serve as an integrative model for the practice of nursing administration. A unique focus of the model is its reliance on economics and human care as the driving forces in nursing administration. This focus results in the nurse administrator role viewed as a combination of: leader of nurses and facilitator in the health care organization (p. 81). Nyberg proposes that these roles are mutually necessary, not mutually exclusive. The caring imperative is related to the quality of services produced which in turn influences revenues and economics. The economic imperative is related to effectively managing the scarce resources of the organization in a manner that will allow for caring. Unfortunately, Nyberg offers no specific recommendations offered for the nurse administrator to promote this mutuality of need. Interestingly, the leadership roles of the administrator are not explored as an avenue for achieving success.

Nyberg again addressed caring in nursing administration in 1993 by focusing on the process of teaching caring to the nurse administrator. A review of literature related to management and caring theories, ethics, women's issues organizational effectiveness and the healthcare industry resulted in the definition of an effective administrator as "...one who cares for self and others. A person who works
with and through colleagues to influence the growth and
direction of the organization toward a state of excellence
and caring in patient care and employee relations" (p. 17).
Although its importance may have been assumed, leadership
was not identified as one of the concepts essential to the
caring nurse administrator. Again, the gap between caring
and leadership is apparent.

Swanson's notion of nursing as "informed caring for the
well-being of others" (1993, p. 352) has implications for
nurses in administrative as well as clinical practice. The
actual caring acts of clinicians and administrators are
frequently hidden, undervalued and virtually undisclosed,
resulting in decreased ability to articulate the "how" of
caring or its effects. Swanson attempts to uncover some of
the hidden components of caring through a structure based on
maintaining belief in people; being emotionally present to
others; doing for others what they would for themselves if
possible; enabling others through coaching, informing,
supporting, offering assistance; and knowing, which is
defined by Swanson as the "anchor that moors the beliefs of
nurses to the lived realities of those served. Knowing is
striving to understand events as they have meaning in the
life of the other" (1993 p. 355). Knowing requires of the
nurse "informed understanding of the clinical condition (in
general) and the situation and client (in specific)"
These caring processes have applicability to the practice of nursing administration. Although Swanson never addresses the nurse administrator, the caring processes identified are descriptive of many nurses in administrative roles. Of particular interest to the administrator, knowing the clinical components of nursing ties the beliefs of the administrator to the realities of the subordinates they serve.

The dichotomy existing between positivist and humanistic paradigms was described in terms of nursing administration by Miller (1987). This dichotomy manifests itself in nursing administration in the competing theories of business management and nursing caring. Like Nyberg, Miller identified the dual forces of human care and economics within the practice of the nurse administrator. Nurse administrators experience increasing pressures from executive staff to adopt a business ethic, a technologic focus, and an efficiency perspective. At the same time, the caring ideal, the moral foundation of practice for the nurse administrator, calls for a humanistic management philosophy. The importance of the nurse administrator's active support of caring values is stressed by Miller, but again, without discussing leadership as a means of achieving this goal.
Summary of Caring and Nursing

Caring as reviewed has been conceptualized as predominately clinical in nature, a way of nurses being with patients. This way of being is viewed in its broadest sense as a moral foundation of nursing practice with outcomes influencing both nurse and patient. The application of caring to nurse administrator practice has been less well developed, and where presented is devoid of explicit links to the leadership components of the administrator's roles. There are, however many aspects of the nature of clinical caring in nursing that have great relevance to the nurse administrator. From this perspective, caring may be viewed as a human attribute realized as a moral imperative in all forms of nursing practice. Caring can be actualized or experienced simultaneously or separately as an affect, an interpersonal interaction, and a therapeutic intervention. Caring cannot be reduced to a list of behaviors, but the outcomes of caring must be identified and their value quantified. Just as nursing practice extends beyond the relationship of nurse and patient, so does caring extend into the many functional areas of nursing practice, including administration. Nurse administrators are challenged to identify their caring work as leaders within healthcare.
Leadership

"One of the most universal cravings of our time is a hunger for compelling and creative leadership" (Burns, 1978, p. 1). Although expressed more than fifteen years ago, this reflection is more compelling than ever in healthcare and in nursing practice. Traditional ways of leading seem to have successfully guided healthcare institutions through the technical changes and transitions which demanded changes in either the goals of an organization or in the means for accomplishing those goals. In the past, environments may not have challenged leadership in the same ways it is being challenged today. Traditional leadership approaches are no longer relevant in an environment of reformation in which organization survival depends on significant alterations in both goals and the means of attempting to reach them. (Kaluzny & Veney, 1977). This review will focus on the transitions of transformational leadership theory as found in the literature of both business management and nursing administration and the challenges for leaders in new environments.

Transitions of Transformational Leadership

The concept and theory of transformational leadership were first proposed by Burns (1978). In his introduction to this new perspective, Burns asserted that the leadership phenomenon was one of the most observed but least understood
on earth (p. 2). The focus of Burns writings was actually on political leaders, but the utility and application of his theory have resulted in its broad dissemination.

Transformational leadership is often best understood when contrasted to transactional leadership. The crux of difference between the two resides in the motives and goals of the leader and followers. Transactional leadership is a process of persons mobilizing resources in order to achieve goals. These persons, leaders and followers, are not engaged in a joint effort to achieve a common goal or collective interest. Rather, they use one another to accomplish separate but compatible goals. This is contrast to transformational leadership in which both leaders and followers strive to achieve mutually held goals. This shared effort is taken despite individual, separate interests, and results from unification in pursuit of "higher" goals. Realization of these higher goals results in the achievement of significant change representing the collective interests of leaders and followers. Transformational leadership may also be viewed as collectively purposeful causation, resulting in the achievement of authentic change. While both forms of leadership can be functional, transforming leadership is evolutionary and essential in cultures and organizations.
undergoing massive changes in goals, aspirations and mission.

Transformational leadership has received attentive study since the first presentation by Burns. Bass (1985) identified three patterns of transformational leadership through a factor analysis of subordinate perceptions. These three patterns of leader factors consisted of charisma, intellectual stimulation and individual consideration. Charisma was defined as "an endowment of an extremely high degree of esteem value, popularity, and/or celebrity status attributed by others" (Bass, 1985, p. 39). Intellectual stimulation reflects the leader's ability to promote strategic thinking in others; to enhance the ability of followers to be aware of problems and solutions. Individual consideration is composed of two factors: concern for subordinates as unique individuals; and development of subordinates.

These three patterns of transformational leadership were further developed by Tichy and Devanna (1986) who identified seven qualities of transformational leaders. Transformational leaders function as change agents, committed to long range change and able to motivate followers. These leaders are visionaries, able to develop and make meaningful to others an image of future possibilities. Value driven, transformational leaders have
the ability to conduct themselves according to a core set of values. Transformational leaders are skillful in handling the complexity, ambiguity, and uncertainty found within the social, technical and political aspects of an organization. These leaders value learning and are open to self-assessment, learning from, rather than hiding mistakes. Intellectually courageous, transformational leaders are strategic thinkers, clearly seeing the strengths and weaknesses of the organization. Finally, transformational leaders have a fundamental belief in people. By focusing on the individual, the leader understands and empowers subordinates to use their full capacity to benefit the organization.

These attributes of the transformational leader were further explored by Hatcher (1991) who proposed that transformational leadership is rooted in spiritual leadership. In this view, the qualities of the transformational leader include inspired vision that discerns and accesses the spirit life of the organization and the self. The leader centers and focuses mind and energy on the vision of the organization. Honesty, authenticity, and integrity result in behaviors consistent with core values. Transformational leaders possess the courage, desire and drive to manifest and achieve their vision. By providing supportive environments, leaders
assist subordinates in becoming empowered. Transformational leaders rely on inspired vision and the ability to focus energies create a strength and power. This promotes encouragement, empowerment and entrusting behaviors with subordinates. Finally, through respect, love and trust transformational leaders create a sense of connection or "web" among subordinates.

These portrayals of transformational leadership serve to provide perspectives both of the one leading and of those who are led. The transformational leader functions from a strong moral foundation, creating and sustaining a vision of the future. This vision and the core values of the leader allow actions which are courageous and serve to create strength and power. By conveying deep regard for the individual, the transformational leader develops subordinates to draw upon their full potential for the benefit of the organization. Achievement of authentic, far reaching change is facilitated by the leader's ability to master the complexities of the political, social and technical aspects of the organization. The nature of the relationships between leaders and followers provides additional perspectives for viewing transformational leadership.
Leaders and Followers

The relationships between leaders and followers have been meaningfully examined from the transformational leadership framework. Avoilo, Waldman & Einstein (1988) used a management simulation game to observe transactional and transformational leadership practices and the relationship of these practices to group effectiveness. Subordinates rated their perceptions of "designated leader" behaviors using a survey based on Bass' leadership framework of three patterns of transformational behavior. Transformational leadership behaviors were found to account for the largest amount of positive financial performance variance between study groups. The nature of a game simulation precluded authentic leader-follower relationships from developing. The study failed to identify specific behaviors of transformational leaders which may have accounted for the differences between groups. In this study transformational leadership was measure using the Multifactor Leadership Questionnaire Bass (1985). The Multifactor Leadership Questionnaire (MLQ) identified, through factor analysis of data collected from military officers, three primary transformational leadership factors: charisma/inspiration, intellectual stimulation, and individual consideration. The MLQ has undergone subsequent factor analyses that report confirmation of the three factor
structures (Avolio, et al., 1988). Examples of items for these factor scales include non-specific leader attributes assigned by subordinates such as: creating enthusiasm, or giving attention. There are no prescriptive leader behaviors which are labelled as transformational leadership. This lack of specificity makes the actualization of transformational leadership difficult at best.

Hater and Bass (1988), reported that top leaders could be distinguished from ordinary managers by higher subordinate rankings of transformational leadership. Transformational leadership was also related to higher subordinate ratings of manager effectiveness and satisfaction. Again, this study relied on the MLQ survey instrument based on Bass' three patterns of transformational leadership and did not include the perceptions of the leaders themselves, nor were specific leadership behaviors identified.

In a variation of leadership research, Kahn (1993) studied caregiving relationship patterns within organizations. This study focused on what were termed caregiving behaviors as demonstrated between staff of a social service agency. Caregiving in this context related to empathy and was not linked to caring theory. The caregiving behaviors and patterns which Kahn identified as essential to promotion of the work of the agency included
many which were similar to Bass' patterns of transformational leadership. Although this link was not established by Kahn clear relationships were found between the ability of the leader to demonstrate these caring/transformational behaviors and the likelihood of them being observed in subordinates. Although the major findings of this study have relevance to leadership performance, Kahn did not specifically examine the leaders or leadership behaviors.

As with the Kahn study on caregiving behaviors, the idea of leadership behaviors being passed down from leader through subordinates was studied by Bass, Waldman, Avolio and Bebb (1987). This study examined two levels of management within a government agency. Subordinates rated first level supervisor leadership performance, while the first level supervisors rated the leadership of their immediate superior managers. This resulted in scores of leadership performance for both levels of managers. A cascading effect of transformational leadership was identified. This cascading effect reflected that transformational leadership behaviors observed at one level of management would also be observed at the next lower level of management, but to a lesser degree. This pattern was attributed to possible role-modeling by leaders, the organizational culture, or the type of subordinate manager.
selected. The nature of the relationships between the managers was not explored, nor was there data from the senior managers regarding possible intentional actions to influence subordinate manager leadership styles.

Lipmann-Blumen (1992) presented an expansion of transformational leadership, called Connective Leadership. This model is proposed to combine traditional masculine leadership ideals with additional female role behaviors which focus on personal relationships. The contrast between the two ideals is much like the concepts of web versus hierarchy presented earlier. The connective leadership model claims to encompass the transformational leadership research work of Bass (1985) and Tichy & Devanna (1986), presenting similar leadership styles. These include collaborating, entrusting, mentoring behaviors aimed at empowerment, persuasion and achievement of vision. Like transformational leadership, connective leadership relies on the leader's deliberate use of self in establishing relationships through which shared goals visions are achieved and the follower is valued.

While the literature has reported follower perceptions of transformational leaders, it has not demonstrated specific behaviors associated with transformational leadership. The leaders' perspectives of their own leadership has not been studied nor is there information to
attest to deliberate efforts intended to use leadership as a force for change. The phenomenon of leadership in nursing administration has been investigated and is reviewed in the next section.

Leadership in Nursing Administration

Examination of transformational leadership within the perspective of nursing administration has occurred with regularity. Transformational leadership was called an "emerging paradigm" for nurse administrators, a more humanistic perspective (Barker, 1990). Transformational leadership, which is moral leadership, is a philosophical approach allowing nurse administrators to influence change consistent with the ethical principles of the profession. The transformational leadership of nurse administrators allows the use of confidence and enthusiasm to motivate subordinates and shape nursing's future (Davidhizar, 1993). Transformational leadership is a means for legitimizing the leadership qualities "associated with women - caring, intuitive, nurturing, relationship oriented" which are demanded in current healthcare organization (Stivers, 1991 p. 47). The acknowledged significance of transformational leadership permits the nurse administrator to use unique skills to promote an environment that cares for patients.

A study of excellent nurse executives provided data on subordinate perceptions and executive self-perception of
leadership behaviors (Dunham & Klafehn, 1990). The participants were identified by administrator peers and faculty colleagues as being excellent administrators. Using a survey based on Bass' model of transformational leadership (Multifactor Leadership Questionnaire), both the administrator self scores and subordinate scores revealed predominately transformational leadership attributes. In this study, those nurse executives holding masters degrees in nursing were perceived as being more transformative than those nurse executives with degrees from other disciplines. Additionally, the investigators compared the nurse executive transformational scores with those from studies previously conducted with non-nursing administrators. The scores of the nurse executives were higher than those of the non-nurses. The investigators reported subordinate scores to be consistently lower than the nurse executive self scores, but failed to comment on this cascade phenomenon of successively lower scores found through layers of the hierarchy.

Similarly, Dunham and Fisher (1990) reported characteristics of nurse executives obtained through analysis of interviews with the nurse administrators. These administrators identified many characteristics that are consistent with transformational leadership theory including: the ability to negotiate and advocate from a position based on values; charismatic personal style; the
value of the unique contribution of the individual; the importance of promoting a clear vision; empowerment of subordinates; and the importance of ongoing growth and learning. These descriptions of characteristics were not related by the authors to transformational leadership theory, nor were specific types of leader behaviors described. Subordinate perceptions were not obtained.

McDaniel and Wolf (1992) tested transformational leadership theory within one nursing department, examining the perceptions of the nurse executive, midlevel administrators and staff subordinates. Using Bass' MLQ, administrators and staff rated the leadership styles of superiors. Administrators also performed self-assessments. As in those studies of non-nurse administrators, the executive nurses consistently had higher self-assessment scores than did the midlevel administrators. The staff scores were also consistently lower than the midlevel manager self-assessment scores. Thus a cascade effect of transformational leadership was identified within this organization. The study supported the diminution of transformational leadership factors as they are passed through successively lower levels of the organization.

Another study of the most important characteristics of nurse leaders asked staff nurses to give opinions concerning their head nurses (Meighan, 1990). Staff nurses selected a
majority of traits which were relationship oriented, such as trusting, considerate, friendly. Included in this list was caring, which was identified by 71% of the respondents as among the most important traits. Despite the identification of caring as an attribute, no linkages were made to caring theories or to the influences of a nursing background. Although there were similarities between these traits and transformational leadership traits, this comparison was not drawn by the investigator. The perspectives of the head nurses were not obtained.

The qualities of the excellent head nurse were also studied by Pederson (1993). Staff nurses were asked to recall and describe an excellent head nurse with whom they had worked. 178 qualities were identified and sorted into categories such as management behaviors, relationship-oriented behaviors, forward thinking, professionalism, advocacy and credibility. Although not explicated by the author, the qualities in these categories were similar to many transformational leadership patterns, including courage, political abilities, belief in people, and risk taking. The study also failed to link the head nurse management qualities with nurse caring behaviors identified by Watson (1989), although there are direct comparisons to be made related to humanistic values, promoting growth and learning, and providing supportive environments.
Caring as a component of the practice of nurse administrators was the focus of few studies. Nyberg (1990) described a research project which examined both economics and human care in the hospital nursing environment. Nurse executives were interviewed to obtain their own definitions and descriptions of the phenomena of economics and human care as experienced in the hospital environment. The executives identified caring as the goal of nursing and economics as a phenomenon which existed in synergy with caring: both permitting and being permitted by the presence of caring. This study also asked staff nurses and supervisors to complete a caring assessment scale measuring the staff and supervisors' perceived importance of caring behaviors. The staff were not asked to evaluate manager caring. Overall, caring was rated as important, and staff scores were higher than supervisor, meaning that staff viewed caring as slightly more important in their practice. No interpretations of this discrepancy were offered. No linkages were made between administrator leadership and perceptions of caring.

Smith (1992) compared perceptions of ideal and actual nurse manager caring behaviors. Nurse managers rated their own beliefs about the importance of caring behaviors, the ideal, and their actual practices related to the caring behaviors. As expected, the ideal scores were higher than
the actual manager caring scores, meaning that the managers valued caring as very important but were not able to actualize caring to the same degree that they valued it. The only variable presented to explain this divergence in scores was familiarity with the literature related to caring theory. There was no attempt to obtain staff nurse perceptions of manager caring.

Duffy (1992) reported relationships between nurse manager caring behaviors and staff nurse satisfaction. The study included staff nurse evaluation of nurse manager caring behaviors as measured by an instrument grounded in Watson's theory of human care (1988). Staff nurse satisfaction was also determined. Overall, the staff perceived nurse manager caring to be high and staff were satisfied. Specific caring behaviors, although measured, were not reported. There was no description of linkages to leadership theory.

Linking Caring With Leadership: Shared Concepts

Although there have been many investigations into both the leadership of nurse administrators and caring within nursing administration, no study had linked the two. In addition, of those studies reviewed, there were no data obtained from the nurse executives themselves about specific behaviors, their preferred leadership styles, or possible
influences of their nursing practice on their work as administrators.

While there have been efforts to explore the phenomenon of caring within the practice of the nurse administrator, there are as yet no parameters for that practice. Those aspects of nurse administrator functioning and effectiveness which may be the unique result of a nursing practice foundation are still unknown.

The elusiveness of such a significant and influential concept as transformational leadership presents an enigma similar to that of caring. Transformational leadership, like caring, is central to meeting the challenges of the healthcare environment. According to Ritscher, "to lead people in the direction they are already going is not especially difficult, but to chart a new course and to persuade people to align with a new vision is a challenge. It requires will, toughness, and intention" (as cited in Hatcher, 1991, p. 73). The requirement is for transforming leadership. The literature related to transformational leadership fails, however, to provide guidance in how one might become a transformational leader. Leadership factors such as charisma, individual consideration and intellectual stimulation hold appeal but lack the specificity necessary for an individual to develop transformational leadership behaviors. Defining the behaviors of transformational
leaders is essential to meeting the challenge of creating transforming leadership in healthcare.

The parallels between transformational leaders and nurse caring behaviors are striking, yet no known studies link the two phenomena in the one place where it would be expected: the framework of nursing administration practice. The gap of knowledge between the two results in a void in understanding the work of the nurse administrator. That void is addressed by nurse administrators in this dissertation. Chapter III provides a detailed review of the process of this investigation.
CHAPTER III

Nursing science has to work at changing its lens to see anew and appreciate some of its beauty, art, and humanity as well as its science. Perhaps the issue for nursing is to acknowledge that it is not like other traditional sciences - it requires its own description, possesses its own phenomena, and needs its own method for clarification of its own concepts and their meanings, relationships and context.

Watson (1988, p. 8)
Method

This study utilized multiple triangulation "to overcome the intrinsic bias that comes from single-method, single-observer, single-theory studies" (Denzin, 1970, p.313). The intent of this study was to reveal the place of caring in the leadership practice of nurse administrators because of its influence on the place of caring in the nurse-patient relationship. Obtaining the administrators' lived world experiences about caring in their practice without examining the subordinates' perceptions of the caring would overlook the impact of leadership within the care delivery environment. The complexity of this multi-layered experience of caring required a research methodology which facilitated examination of the concept from many perspectives. Multiple triangulation can reveal both complexity of nursing practice and the context of that practice (Banik, 1993). According to Mitchell (1986), multiple triangulation provides a significant means for capturing the substance of a phenomenon under investigation.

This chapter reviews the processes of applying multiple triangulation, including pertinent principles of
application. The procedures for data collection including the selection and characteristics of the study participants are described. Finally the processes of data analysis and verification of evaluative rigor are presented.

Triangulation Study Design

Triangulation is the predetermined, systematic combination of complementary research techniques. Denzin (1970) has described four basic types of triangulation: theory, data, method, and investigator. Multiple triangulation uses multiple types of these four basic approaches (Mitchell, 1986). Although originally applied for purposes of confirmation of accuracy of data and findings (Denzin, 1970), triangulation has more recently been identified as a means of establishing completeness (Knafl & Breitmayer, 1991). The notion of completeness relates to increasing the depth and breadth of understanding of the phenomenon under investigation. The multiple data sources, theoretical frameworks, or methods are not expected to confirm one another. Rather the expectation is achievement of a more holistic grasp of the phenomenon; one that is enriched through the complementary contribution of each data source, theory and method.
Rationale, Purposes and Benefits of Triangulation

The decision to triangulate in this dissertation was based on the complexity of the practice of nursing administration and the effect of that administrative practice on subordinates. The endeavor to obtain a deeper understanding of the uniquely paired concepts of caring and leadership in nursing administration could be accomplished through multiple triangulation.

In this study, four types of triangulation were combined to uncover the place and meaning of nurse administrator caring for both the administrator and for the subordinate. The triangulation included: theory (Transformational Leadership Theory by Burns, and Human Caring Theory by Watson); data (data sources included nurse administrators and their staff nurse subordinates); methods (between-methods triangulation used data from interviews, a qualitative approach, and quantitative data obtained from a structured survey, Likert scale instrument); and finally, investigator triangulation was employed in the process of data analysis. An explanation of each of these types and their application to this study follows.

Types of Triangulation

Theoretical triangulation allows for the application of several theoretical frameworks in the analysis of the same set of data. Alternative explanations of the same
phenomenon, in this case nursing administrative practice, were explored through theory triangulation (Kimchi, Polivka, & Stevenson, 1991). In this study, both Transformational Leadership Theory and Human Caring Theory were "considered together and tested within the same body of data" (Mitchell, 1986, p. 20). These theories were selected to explain the process of caring as embedded in the leadership of nurse administrators. The combination of these two theories was chosen to gain insights into the caring phenomenon of nursing leadership which were not explained by either theory alone. Approaching the investigation from multiple perspectives resulted in greater significance of the findings (Banik, 1993).

Data triangulation provides the opportunity to use multiple data sources to test how a phenomenon is experienced by different groups (Murphy, 1989). Sources of data are chosen to represent different perspectives and diverse data about a single phenomenon (Mitchell, 1986). The use of these multiple sources with a similar focus provided diverse views of the topic of caring in administration and contributed to validation of the research findings (Kimchi et al., 1991). Data sources for this research included nurse administrators and their staff nurse subordinates. These different data sources allowed discovery of those aspects and dimensions of caring which are commonly
experienced and those which are different.

Methods triangulation employs dissimilar research methods to collect data about the same phenomenon. The methods selected must have strengths and limitations which counterbalance one another (Banik, 1993). This research used both qualitative and quantitative methods including interviews with nurse administrators and a structured survey administered to administrators and their staff nurse subordinates. The interviews focused on the nurse administrators' perspectives on leadership and caring, while the surveys measured staff nurse perceptions of manager caring behaviors.

Mitchell (1986) proposed four principles to be applied in the use of methodologic triangulation. The first principle requires a research question which is clearly focused. The research question and purposes proposed for this study were carefully matched to the problem and kinds of data needed. The two methods chosen, qualitative interview and quantitative survey, were selected to complement one another, thus meeting the second principle. The use of qualitative interview methodology permitted in depth exploration of a previously unexplored aspect of nursing administration, while the use of a quantitative survey method resulted in obtaining the perceptions of the subordinate staff of the nurse administrators. By choosing
complementary methods, a more complete portrayal of the phenomenon was achieved. These rationale also apply to the third principle which requires that the "methods are selected according to their relevance to the nature of the phenomenon being studied" (p. 23). The final principle proposed by Mitchell recommends ongoing evaluation of the methods chosen throughout the study to insure that the first three principles are followed. This was accomplished through the investigator's ongoing assessment of the validity of data collected, and its relevance to the research question and theoretical frameworks. Simultaneous methodologic triangulation (Morse, 1991) was used to obtain differing but complementary data on the phenomenon of caring. This was accomplished by obtaining qualitative data from administrator interviews and quantitative data from subordinates' and administrators' survey responses. This between-method approach as described by Mitchell (1986), while of a higher level of complexity, resulted in multiple perspectives of the experiences of caring nurse administrators.

Investigator triangulation took the form of two individuals coding the interview data. This approach was taken in an effort to strengthen the reliability of the data analysis by bringing specific expertise to the project (Murphy, 1989; Duffy, 1987). Analysis of the qualitative
data by more than one investigator resulted in an expanded and enriched interpretative process. Additional information on this topic is presented later in this chapter as the data analysis processes are reviewed.

Analysis triangulation has only recently been proposed as a means for avoiding "the personal biases of investigators...and thus increasing the validity of the findings" (Kimchi et al., 1991). Latent and manifest content analysis techniques were combined with the constant comparative technique of data reduction to better enable identification of patterns and themes in the interview data.

The study of both the administrators' experiences of caring and the subordinates' perceptions of this caring in the work environment, while necessary to obtain a more complete understanding of the phenomenon, presented a complex research methodology challenge. Davidson and Ray (1991) presented a paradigm to facilitate understanding of the complex relationships of humans and their environments. This paradigm is instructive in understanding the application of multiple triangulation in research which investigated nurse administrator caring. According to Davidson and Ray (1991)

multiple modes of inquiry can be used to make significant contributions to nursing science, to improve the problem solving ability of theories, and to
enable nurses to create caring environments that affirm both nurses and those for whom they care (p. 84).

Collecting Data

This section describes the process of collecting data about the experience of caring in the practice of nurse administrators. Included are the selection and characteristics of participants, the use of a pilot study, ethical considerations, and the procedures for data collection which consisted of interviews and survey instruments.

Selection and Characteristics of Participants

The purposive, theoretical sampling method was used to obtain the nurse administrator and staff nurse subordinate groups at each of six institutions. This sampling method was chosen to provide participants "who can provide rich descriptions of the experiences under study" (Wilson & Hutchinson, 1991, p. 269).

The sample was drawn from a population of 50 nurse administrators of cancer care programs who attended national meetings. All nurse administrators who attended these meetings were extended an invitation to participate in the research and 15 accepted the invitation. The selected study participants were nurse administrators practicing in acute care facilities in the eastern United States with a major
emphasis on cancer care. This sample was selected to attempt to take into account the influence of organizational culture on leadership style. In addition, those nurse administrators who choose to practice in the field of oncology may share common values and perspectives. Participant selection came from different locations in the eastern United States to avoid the possibility of local bias. Participants worked in practice settings that included university medical centers, cancer research facilities and large community hospitals. The final selection of participants was based upon their expression of interest in the purpose of the study, geographic distribution of sites, and type of facility or institution to allow for broad representation. The administrator informants selected from this population also met the following criteria: (a) they had operational responsibility and 24 hour accountability for comparable inpatient cancer services and (b) they had been in their current position for at least twelve months prior to data collection.

Subordinate participants were self-selected from the population of staff nurses, working on inpatient, medical oncology units within the cancer center, who reported to the interviewed nurse administrator. This process resulted in data collection from pairs consisting of a nurse administrator and her/his group of subordinates from each
institution. Staff nurse subordinate participants self selected because all nurses on the identified units were given the opportunity to participate and given surveys with the understanding that participation was voluntary.

The administrator participants in this sample were all female, ranging from 34 to 53 years of age; their nursing experience range was between 14 and 31 years and their experience in their current position ranged from two to ten years. Five of these participants held master's degrees and one held a doctorate. (Table 1)

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*Education Code: 1=Nursing Diploma, 2=Associate Degree, 3=Bachelor's Degree, 4=Master's Degree, 5=Doctoral Degree

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The subordinate participants' mean age range was from 29 to 40 years; their educational level was from diploma to master's preparation. The subordinate participants' mean nursing experience ranged from four to over 15 years, while their mean experience in their current unit ranged from two to six years. (Table 2)

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* Education Code: 1=Nursing Diploma, 2=Associate Degree, 3=Bachelor's Degree, 4=Master's Degree, 5=Doctoral Degree
On average the administrator participants were 11.8 years older than their staff nurse subordinates. The administrators had, on average, 15 more years of nursing experience than their subordinate participants; however the administrators' average experience in their current position, was 5.25 years, which was more closely compared to the average 4.3 years of subordinate experience on their current unit.

Pilot Study

A pilot study consisting of one nurse administrator and a group of staff nurse subordinates from the same institution was conducted. The pilot study was designed to allow the investigator to evaluate the interview process and questions to determine if the desired types of information were being obtained. In addition, the pilot study provided the opportunity to evaluate all portions of the data collection and analysis methodologies prior to initiating the major study.

No problems were encountered in the pilot study; no changes were made in the interview guide nor was the data analysis plan altered as a result of the pilot study. Data obtained from the pilot study was included in the final data analysis of this research.
Ethical Considerations

An "Informed Consent Statement" was reviewed with and signed by each of the six administrator participants (see Appendix B). The consent statement consisted of a review of the purpose of the study and the rationale for including interview data; the process for analysis of the interview data; the purpose and nature of the survey instrument; provisions for maintaining participant confidentiality and the degree of anonymity possible; provisions for publication of the data; and responsible persons to be contacted regarding concerns or questions about the study. The administrator participant signature on the consent form indicated comprehension of the consent statement, and authorization of use of interview information in publications and presentations.

Subordinate participants read an "Informed Consent Statement" attached to the survey instrument (Appendix C). This consent document also reviewed the purpose of the study; the requirements of participation, including the ability to withdraw at any time; provisions for anonymity; and persons to contact for questions or concerns. In order to provide anonymity and increase their comfort with candid responses, staff subordinate participants were not asked to return a signed consent form, and the survey instruments were coded only with a five character string of numbers.
The dissertation proposal was reviewed by the George Mason University Office for Research and received exempt status. In addition, the study proposal was submitted for institutional review and received approval at each of the six data sites.

Data Collection and Interviews

Data collection occurred over a fourteen month period. The process consisted of the initial inquiry of potential participant interest, review and explanation of the purpose and procedures of the study, selection of the study participants, institutional review and approvals and the actual collection of the data.

Administrator Participants

Administrator interviews were directed at gaining an understanding of the phenomenon of caring as it is experienced in the leadership of the nurse administrator. Informants were asked to describe their experiences with the phenomenon of caring. Interview was selected because, "The way people talk about their lives is of significance, that the language they use and the connections they make reveal the world that they see and in which they act" (Gilligan, 1982, p.2). As initially planned, five informants were interviewed beyond the pilot study. Saturation, or repetition of findings was readily achieved during the course of these six interviews (Morse, 1991).
The nurse administrator participants were interviewed in a place of their choice, for one to two hours, using an open-ended, semi-structured format (Appendix D). To insure reliable interview data, a standardized interview format was developed which includes specific prompts. The interview format statements were sent to the participants prior to the interview for their review. Nurse administrators were asked to tell their stories about their nursing leadership. The informants were asked "What is it like to be caring as a nurse administrator?" Informants were specifically asked to relate examples of how they experienced caring when they provided patient care and how they experienced caring in their leadership. The interview format was designed around the following areas of content:

- Generation of a list of terms or phrases that the informants used synonymously with caring including a contextual description.

- Collection of administrative exemplars or paradigm cases which the informant cites from administrative practice that illustrates caring and non-caring in leadership.

- Identification and review of the meaning of caring for each informant.

Content validity was determined by having the interview instrument reviewed by an independent expert in caring theory and administration (Kahn & Steeves, 1988, p. 203)
Interviews were audio taped using a microcassette recorder. Each interview was then transcribed verbatim by a transcriptionist. The interview transcripts were evaluated for accuracy through the following methods: (a) the investigator read each transcript while listening to the corresponding audio tape, correcting any errors; and (b) interview transcriptions were sent to informants to review for accuracy and for the opportunity to add any further thoughts. In addition, any individual or institutional names were excluded from the transcripts, and pseudonyms were inserted to ensure confidentiality. The audio tapes were erased after the completion of data analysis.

In addition to interviews, each administrator participant was asked to complete the Caring Assessment Tool-Administrative Version (CAT-A) survey to rate themselves (Duffy, 1992). This is a 94 item Likert-type scale instrument which measures staff nurse perceptions of nurse manager caring from low-caring to high caring (Appendix E). Duffy (1992) reported a Cronbach's alpha for internal consistency reliability of the CAT-A to be 0.9849. The Cronbach coefficient for internal consistency reliability as measured in this study was 0.976. While these values may have been influenced by the small sample sizes, both alpha levels are indicators of exceptional
instrument reliability. The administrator participants were asked to complete the survey as a self-assessment of how they believed their staff subordinates would respond. The individual administrator CAT-A scores were then compared with the mean CAT-A scores of the matched staff nurse subordinates.

Subordinate Participants

The Caring Assessment Tool-Administrative Version (CAT-A) was administered to the subordinate staff nurses in each institution. The subordinates were given an oral presentation of the purpose of the study and the requirements for participation. The investigator remained present to respond to any questions and to collect the surveys, although some staff elected to return their surveys by mail. The number of staff nurses who chose to participate ranged from eight to thirteen among the six data sites for a total of 62 participants.

Self-As-Instrument

Rew, Bechtel and Sapp (1993) described the concept of "self-as-instrument" which acknowledges the investigator not only as the collector of data but also as the "instrument" through which data are collected. Rew proposed that qualitative researchers describe the use of self as the primary instrument for data collection and address attributes which contribute to rigor in data collection.
These attributes are addressed later in this chapter under Evaluative Rigor.

**Analyzing the Data**

The interview transcripts underwent content analysis. Textual data were interpreted by looking for common categories in the meanings of the leadership experiences of each administrator. The survey data were scored and summarized with descriptive statistics. This section will review the processes of data analysis including: content analysis and the theoretical frameworks for this content analysis; the interview data reduction processes; and the quantitative analytic processes.

**Content Analysis**

Content analysis has been proposed as a systematic approach to allow access to the rich data in the thoughts, words, attitudes, and personalities of interview participants (Waltz, Strickland, & Lenz, 1991, p. 299). It has been recognized to have five distinctive features which make it useful in this study. First, the analysis is applied to recorded information which allows for an exact review of the original interview communication, decreasing the possibility of data becoming "lost" in translation. Second, the emphasis of content analysis is on the actual content of the words chosen by the interview participants. This approach was particularly well suited to the purposes
of this study related to leadership and caring concepts. Third, the actual procedure of content analysis includes the application of explicit rules which are designed to achieve relative objectivity. These rules were applied to the processes of examining the recorded information and permit replicability of the analytic process. The fourth distinctive feature is the systematized application of specified criteria in the processing of content analysis. These procedures were predetermined and applied consistently throughout the analytic process. The final feature of content analysis is the deliberate reduction or simplification of the data which resulted in some degree of loss of the original richness, but allowed for the discovery of new dimensions of the meaning of caring and leadership in nursing administrative practice.

This study followed the content analysis process developed by Catanzaro (1988). The process provided a means for taking the unstructured data from participant interviews, organizing this data into patterns, and cross-validating the information for interpretation (Catanzaro, 1988, p.437).

**Manifest and Latent Content Analysis**

Content analysis has been described by two types or approaches; manifest and latent (Babbie, 1989). The application of each of these types in this study is reviewed
Manifest Content Analysis - Manifest content analysis involves the application of predetermined units of analysis to the words of the interview participants. This study employed thematic content analysis which was based on categories derived from Transformational Leadership and Human Caring theories. Predetermined codes, deductively generated from these two theories were applied to the interview data. These codes were descriptive of the behaviors or factors associated with transformational leadership and caring behaviors. Each interview transcript underwent this thematic content analysis on two occasions; once from the framework of transformational leadership and again from the framework of human caring theory. A summary review of both of these theory based coding schemas is presented.

The framework for analysis of transformational leadership was derived from a combination of the works of Bass (1985) and Tichy & Devanna, (1986). There are a total of eight (8) leadership characteristics, falling into three categories of leader qualities. The eight characteristics served as the designated transformational leadership code factors. These leadership attributes were characterized as follows:
Charisma/Inspirational: This reflects the high degree of esteem, popularity and status which is attributed to the leader by others.

1. Change Agent - commitment to a long range path of change and the ability to motivate others to move along the path with them.
2. Visionaries - the ability to develop an image of the future and its possibilities and to make the vision meaningful to others.
3. Value Driven - ability to perform behaviors which are consistent with a core set of values.
4. Courageous - the ability to espouse a position based on vision and values both to those who do and do not want to hear the position.

Intellectual Stimulation: The ability to promote strategic thinking in others; to enhance the ability of others to be aware of problems and solutions. Three characteristics describe the capacity for creating, sustaining and implementing intellectual stimulation in others:

5. Ability to Handle Complexity, Ambiguity & Uncertainty - leader's mastery of the social, technical and political aspects of the organization/enterprise.
6. Quality of Life-Long Learning - openness to self-assessment and new ideas; learning from mistakes rather than hiding them.
7. Intellectual Courage - strategic thinking which clearly sees the strengths and weaknesses of the organization.

Individual Consideration: Concern for subordinates as unique individuals expressed through one-to-one focused interactions; the development of subordinates through delegation, team building and mentoring.
8. Belief in People - the ability to focus on individual consideration; understanding and empowering subordinates to use their full capacity to benefit the organization. Coding schemas follows.

The framework for analysis of caring behaviors was based on Watson's Human Caring Theory (1988) and the work of Wadas (1993). Watson described carative factors or behaviors which became the code factors for this thematic
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analysis. These caring factors are described as follows:

1. Humanistic-Altruistic System of Values
   This value system is based on kindness, love for others, candor, empathy and concern for others.

2. Faith and Hope
   This value of nurturing and instilling faith and hope in one another encourages expression of beliefs and values. These beliefs and values are seen as significant influences in the ability of the individual to have faith and hope in something beyond themselves.

3. Sensitivity to One's Self and Others
   This factor/behavior allows self to recognize and feel one's own emotions and recognize the emotions of others. This sensitivity allows the nurse to promote wellness in others. (N.B. Watson also maintains that nurses engaged in transpersonal caring sense and accept the feelings of clients, mirroring them back to the client and thereby facilitating the client recognition of and ability to deal with the feeling; when this has occurred, healing can begin).

4. Development of Helping-Trust ing Relationships
   This type of relationship evolves from a particular quality of communication which connotes a high regard for the whole lived experience of the other person.

5. Promotion and Acceptance of the Expression of Positive and Negative Feelings
   Feelings which influence thoughts, behavior and experience must be acknowledged and considered. Action on this factor can allow for the development of a deeper, more honest caring relationship.

6. Creative Problem-Solving Processes
   The use of aesthetic, personal, intuitive, affective, ethical and empirical domains of knowledge to create a wholeness of knowing in problem-solving.

7. Promotion of Transpersonal Teaching-Learning
   This factor requires the nurse to be open to the knowledge, abilities to solve problems and
creativity of others. The nurse must be capable of tuning into and gauging the perceptions and feelings of another in order to promote learning.

8. **Providing a Supportive, Protective &/or Corrective Mental, Physical, Societal and Spiritual Environment**

   This factor addresses the environment within which care is given and healing takes place. Comfort, Privacy, Safety and Clean aesthetic surroundings contribute to the nurses' ability to provide such care.

9. **Assistance with Gratification of Human Needs**

   This addresses the human needs described by many; they may be grouped as survival needs (food/fluid, air etc.); functional (activity, sexuality); integrative (affiliation, integration, achievement); and actualizing (inter- and intrapersonal growth, spiritual, transpersonalization).

10. **Allowance for Existential-Phenomenological-Spiritual Forces**

    This factor is based on the ability of one human person to be open to and receive another human person's expression of feeling, to empathically experience those feelings for oneself, and develop an appreciation for the inner world of the experiencing person. Through this process the nurse creates an opening for healing. This factor results in benefit not only for the one being cared for but also for the caregiver by giving focus and meaning to the work of the nurse.

**Latent Content Analysis** - The process of latent content analysis results in the emergence from the interview data of inductively generated codes which remain grounded in the data. This type of content analysis is attentive to the meaning hidden within the textual material itself. During this process of latent content analysis, incidents were coded according to categories and then compared to all
previously coded interviews in the same category. As recommended by Catanzaro (1988), these categories arose from the interview data themselves. In total, sixteen code categories emerged from the interview data through this process. These codes related to the ways in which the participants viewed their work as nurse administrators.

Coding and Memo Processes

The interview transcripts were reviewed, analyzed and coded according to the manifest and latent content analysis techniques previously described. This meant that the investigator analyzed each transcript on three occasions: first from the framework of transformational leadership; second from the framework of human caring theory; and third from a latent content analysis perspective searching for meaning and categories embedded within the interview data. The codes were entered into the Ethnograph, a computer assisted data text and analytic system (Seidel, 1988). The investigator maintained written memos throughout the analytic process. These theoretical memos contained information about the deliberate attempts to glean meaning from the data and provide order to the process of analysis.
Data Reduction: Drawing Conclusions

The process of coding the interview data involved a deliberate quest for recurring themes which represented patterns. Those categories resulting from the content analyses were examined, organized into clusters and then grouped into themes. These themes were judged by the criteria recommended by Catanzaro (1988) which include: the data placed into each category or theme fit together in a meaningful way and pattern; and there were clear differences among the themes. This was a creative process which required meticulous decision making procedures about the relevance and meaning attributed to codes found in the interview data. The memoing procedures described previously assisted in this process. The investigator is well grounded and experienced in both nursing administration and oncology. This grounding also facilitated the content analysis.

Catanzaro (1988) presented a series of tactics to be employed in the process of drawing inferences and conclusions about the meaning of interview data. These tactics, originally proposed by Miles and Huberman (1984) include: (a) counting, (b) noting patterns and themes, (c) seeing plausibility, (d) clustering, and (e) establishing conceptual or theoretical coherence. A brief review of the application of each of these tactics follows.
Although qualitative research methodology is concerned with the quality or features of the data, counting can provide a way of quantifying the facts to learn about the distribution of these features or qualities. Unlike quantitative content analysis, which stops with the presentation of tabulations of code counts, qualitative content analysis in this study used counts to lead to "the crucial further step of interpreting the pattern that is found in the codes" (Morgan, 1993 p. 115). Through the use of counts, patterns were located in the data. These patterns were then examined to determine why they occurred in the manner that they did. Though depicted as sequential or linear operations, the actual processes of coding, counting and interpretation were the result of moving between the parts of the interview texts to the whole texts, to the other texts and back again.

The second tactic, noting patterns and themes, has been made analogous to clinical decision making. That is, it is an intuitive process and while constantly occurring, it is difficult to describe. In this study, the investigator recognized patterns and themes intuitively while reading, coding and rereading the interview texts. The memoing process as well as the ability to predictably locate such patterns elsewhere were strategies used to confirm these patterns.
Seeing plausibility, the third tactic, describes the sense of something seeming true, honest or trustworthy. In this study the themes seemed plausible and were consistent with the experiences of the investigator and non-participant nurse administrator colleagues of the investigator.

The process of clustering was used in this study to group data together in ways that gained a better understanding of the phenomena under investigation. Codes were examined to determine which were alike or unalike each other, and then grouped or clustered into gradually more general theme categories.

The last tactic used in the process of drawing and verifying conclusions involved making coherence of the findings as they relate to other studies, frameworks and theories. This involved the investigator linking the findings of the study to concepts from the literature in a way that accounted "for the how and the why of the phenomena under study" (Catanzaro, 1988, p. 449).

**Quantitative Analytic Process**

Quantitative data from the CAT-A surveys completed by administrators and subordinate staff nurses were coded and entered into a data base. Descriptive statistics were used to summarize the data. The CAT-A surveys were scored with a total caring score assigned to each. The possible range of caring scores was 94 (low caring) to 470 (high caring). A
mean total caring score was obtained for each institutional
group of staff nurse respondents. The mean staff score from
each institution was compared to the corresponding
administrator self score. The mean staff scores were also
compared among the six data sites, looking for patterns.
These survey score comparisons were made for the purpose of
complementing the findings from the administrator
interviews; providing another perspective.

**Evaluative Rigor: Confirming Findings**

The need for establishing evaluative rigor in
qualitative research has been described frequently and with
intensity by multiple authors. The notion of confirming
findings has been approached from several differing
perspectives, but Lincoln and Guba's (1985)
conceptualization of "trustworthiness" has applicability to
this study. Trustworthiness in this conceptualization is
operationalized as addressing credibility, transferability,
dependability, and confirmability.

**Validity: Confirming the Findings**

Credibility lies in the accurate description of the
phenomena under investigation and was achieved through the
investigator spending time in each research setting
interacting with staff. This contributed to investigator
understanding of the organizational context and facilitated
placement of the analyses and interpretations into those
contexts. The investigator spent time in each data site to allow interactions with individuals other than the study participants and thus gain additional information about the context of the settings. Triangulation also contributed to credibility and precision in this research by measuring the same quality with multiple techniques.

Transferability parallels the positivist-empiricist concept of external validity and describes the generalizability of study findings. The investigator demonstrated transferability through theoretical sampling which resulted in rich descriptions sufficiently inclusive to allow comparison of recurring themes and patterns across data sites.

Dependability was achieved through a data inquiry audit and data triangulation. The audit trail involved data being organized and systematically maintained to allow inquiry audit by an independent, non-nurse reviewer. Data triangulation has been previously discussed.

The fourth process described by Lincoln and Guba (1985) is that of confirmability. Confirmability is achieved through the inquiry audit and triangulation, both of which have been previously described. Sandelowski (1986) described the concept of consistency which goes beyond confirmability by requiring the presentation of sufficient data in the interview text examples to allow the reader to
confirm and validate the data. Independent nurse administrator readers of these texts have validated the themes of caring leadership in nursing administration.

The investigator's use of "self-as-instrument" as described by Rew et al (1993), provided additional opportunities to address issues of methodologic rigor. The attribute of appropriateness concerns the ability of the investigator to be clear about the purpose of using "self as instrument" for data collection. The investigator posed interview questions in ways that were intended to decrease ambiguity and avoid confusion about the role of the investigator as researcher, not clinician. Authenticity was used by the investigator to respond to the administrator participants in a manner which was congruent with personal attitudes, values and beliefs. This response was predicated on the investigator's ability to use personal history and awareness to accurately perceive and respond to the interview participants (Rew et al, 1993, p. 300).

Credibility of the "self-as-instrument" was achieved by the investigator's ability to develop trust and rapport with the interview participants prior to, during and after the interviews. Intuitiveness allowed the investigator to use immediate connection and empathy to synthesize the experience of the informants. The investigator's use of intuitiveness resulted in the engagement of the "self-as
instrument" with the life experiences of the participants. Through this engagement the investigator became a medium or vehicle through which the participants' experiences were later expressed. The effects of these initial engagements were later experienced every time the interview transcripts were reviewed by the investigator, allowing for a more complete comprehension of the meanings expressed. In addition, through the investigator's use of self-as-instrument, patterns and themes that emerged from the interviews were able to be mentally collected and later noted in memos for consideration in the process of textual analysis.

Through receptivity the investigator was open to feedback and communicated willingness to interact with the participants in their particular contexts. Receptivity allowed the investigator to incorporate this contextual information into the interpretation of findings. Finally, reciprocity and sensitivity allowed the investigator to work with the participants as co-researchers and to have the ability to see and hear accurately the phenomena as experienced by the participants.

Establishing Reliability

Reliability is used to assess the extent to which the data collected are representative of the actual phenomena rather than the bias of the investigator or procedures. In
this study reliability was established through reproducability or intercoder agreement (Catanzaro, 1988). Reproducability was established though the process of investigator triangulation. The advantage of using investigator triangulation in the analytic process lies in the neutralization of biases. The investigator of this study as well as an individual experienced in qualitative analytic procedures engaged in separate codings of all of the interview transcripts. This individual, while experienced in staff development administration, had no particular experience in cancer care or in supervising cancer services. Coding proceeded according to the manifest content analysis procedure previously discussed. Both sets of interview codes were reviewed and agreement was noted between the analyses. There were fewer than five instances of coding differences per code category in each interview between the analysts. When viewed within the context of the hundreds of codes actually assigned, this represents excellent reproducability. This high rate of agreement is in part a reflection that the codes were not assigned in a mutually exclusive approach and that there were many instances of two or more codes nesting or overlapping the same text content.
Summary

This chapter has provided a detailed review of the methods used throughout the collection and analysis of data for this study. In addition to a thorough review of the principles and application of multiple triangulation, features of the selection and characteristics of the participants, pilot study and ethical considerations were presented. The processes of data collection were described. Data analysis was reviewed including a description of approaches to the qualitative and quantitative analyses. Finally, the issues of evaluative rigor and their application to this research were delineated. The ongoing process of interpretation of the data is presented in the next chapter.
I reject definitions and interpretations of science and scientific inquiry that bury the quest for discovery, beauty, creativity, and a higher sense of being-in-the-world. I want nursing to move beyond objectivism, verification, relationships, context, and patterns. I want nursing to be more concerned with the pursuit of hidden truths and new insights, developments of new knowledge in relation to human behavior in health and illness, and to make new discoveries of how to be in a professional human caring relationship with individuals to serve society."

Watson (1988, p. 2)
Findings, Analysis, and Interpretation

The overall purpose of this dissertation was to generate an understanding and structure of the experience of caring as a component of the leadership practice of nurse administrators. Caring and transformational leadership were revealed through manifest and latent content analysis of in-depth interviews with six nurse administrators of cancer care services and through staff subordinate perceptions of manager caring behaviors. This chapter presents findings, analysis, and interpretation of the data obtained from nurse administrators and their subordinates. The concepts of both caring and transformational leadership as revealed in the analysis of interview data are reviewed and related to the literature. In addition, the administrators' self ratings and subordinates' ratings of nurse manager caring behaviors are reviewed within the contexts of both the interview data and each individual organization.

As discussed in chapter three, the actual counts of codes will be presented and discussed as both a descriptive and interpretive process, with emphasis given to the examination of the patterns of the data. These patterns of
code occurrence were further reduced into three themes which explain why the patterns occur in the ways that they do (Morgan, 1993). The three themes which emerged from the content analysis and data reduction processes are discussed in depth and serve as the organizing framework for the chapter.

Each administrator participant became actively involved in the interview process, engaging in animated and at times intense revelations of their perspectives of nursing leadership. The interviews provided an opportunity for the participants to attentively reflect on aspects of their work which had become submerged in the prosaic of daily demands. The themes which emerged from these descriptions depict the intertwined nature of caring and transformational leadership in nursing administration practice.

Themes

The six participants spoke of their practice and experiences as nurses and as administrators. A total of thirty-four (34) codes were assigned; ten of these codes were from the Human Caring Theory framework, eight (8) from Transformational Leadership Theory, and sixteen (16) emerged from latent content analysis. Each of the participants' interviews had coding evidence of all the caring, transformational leadership, and latent content analysis factors. As coded data from the interviews were reviewed
and sorted, clear patterns emerged in the ways that codes surfaced. These patterns were reduced and organized into three themes:

1. A person centered value system rooted in the reality of clinical practice
2. Courage and sensitivity in decision making
3. The intentional cascading effect of caring leadership

There is a remarkable clarity throughout each of the participant interviews regarding these themes. The themes describe ways in which the participants 'do the work' of nurses who are administrators. The participants describe themselves and their work as complementary to but different from other administrators who are not nurses. There was a confidence in the responses of the participants that is compelling and present throughout the data.

Each theme will be reviewed individually. The factors which constitute the pattern of the theme will be examined. The relationships found among the themes within each pattern will also be described. The words of the participants will be used to emphasize and support the themes. Pseudonyms are used to protect participant confidentiality.
Theme 1-- A Person Centered Value System Rooted in the Reality of Clinical Practice

The participants spoke frequently of the importance of their focus on the person-centered/humanistic aspects of their work. This focus provided a value system for their administrative practice. The caring factor Humanistic-Altruistic System of Values and the leadership factors Value Driven Behaviors and Belief in People were clearly present. Together, these three codes had a combined frequency of 166 participant statements and were among the highest frequency of all codes. Additionally, three other factors which emerged from the data were linked to the patterns of this theme: Clinician Identity, Knowing the Clinical, and Patient Focus. These three factors had a total frequency of 39 statements and were found in all six participant interviews.

The six factors in this theme recurred throughout the interviews in consistent patterns. Participants spoke of their basic beliefs in the goodness of people and their feelings of kindness and love for their colleagues. Throughout the interviews the participants described value driven behaviors which are consistent with their beliefs and with the coded factors. Value driven behaviors were evidenced throughout discussions about belief in people and humanistic-altruistic values. Participants also talked
about how they had retained their clinician identity, how this identity relates to an intense need to know about the clinical work of subordinates, and how both are tied to a bottom-line focus on the patient as recipient of care.

**Humanistic-Altruistic System of Values and Value Driven Behaviors.** The kindness, love for others, candor and empathy in administrative practice is strikingly revealed in the interviews. This factor was the second most frequently coded caring factor (n=39) in the interviews and is the only caring factor in this theme. The humanistic/altruistic factor provides a value system for the administrators' practice. The participants described their feelings for and about the staff with whom they work:

> I care about how people get better [in their work performance] and how they feel about themselves. That they come away from making tough decisions feeling that they've succeeded. (Jackie)

> You become the caregiver for the staff and for your leadership group and you're doing some of those same kinds of things in your caring about their professional growth, about their personal things that may be going on for them, about their successes, about their disappointments. You do some of the same things, the same behaviors [but] now with staff, and not directly with patients. (Sandra)

> There were clear expressions of the significance to the nurse administrator of caring for subordinates and colleagues. According to the participants, nurse administrators will place priority on those activities which are viewed as humanistic in focus:
I think that nurse administrators probably take a little bit more time for the people time. I don't have any facts to [support] that but just from my own experience I think if they have half an hour they [would] sooner spend it with some face time and one-on-one and getting information from the individual personally versus to sit down and read a report from that person. (Lynn)

The humanistic/altruistic values were a basis for administrator action. The participants described touching examples of how they actualized these humanistic/altruistic values.

My caring sometimes I think is little [things]. I do a lot of sending cards. Anytime any of the staff have a parent who dies I send a note. I get cards for people who are having problems, just kind of the 'thinking of you' sort of thing. We recently had a physician here who died and it was very trying on the staff. He was a young physician and some of the staff was very, very attached to him. So I keep checking in on those staff like the nurse who had been his clinic nurse and the nurse who had cared for him at night who was his primary nurse. I think these are caring things that I can do when people are in trouble. You always have somebody in trouble. (Sandra)

Participants often described experiences as clinicians or personal experiences which clearly shaped their humanistic views in later life.

Nursing itself is nurturing, is caring, concern for others and I look at it in terms of the holistic approach in terms of the family. I guess I think of it in terms of having gone through it with my own family....Not having been cared for, what were the things that were missing...for the family and what could I do when I was in a leadership position, what could I do to make sure that those components were there? (Diana)

We work with very caring people, very patient oriented people. I think I was really very fortunate that I had that experience early, that really shaped my approach
to patients because I always worked with other people who were patient advocates, who genuinely cared....Those early experiences clearly shaped me. (Karen)

This factor provides administrators with a basis for a value system on which to base their practice. The participants gave examples of the significance of caring for others. There were instances in each of the administrator interviews where clinical or early personal experiences sensitized the participants to the importance of a humanistic approach, and this sensitivity later permeates their leadership. These humanistic-altruistic values were further echoed in the participants' reflections on their belief in people.

**Belief in People and Value Driven Behaviors.** The participants again were remarkably clear in their descriptions of the importance of believing in people as a component of their value system. Belief in people was coded in every interview (n=55) and was the second most frequently occurring code factor overall. Frequently these expressions of belief in people occurred temporally in the interview when discussions of a humanistic viewpoint were expressed. More than being viewed as simply 'niceties', the participants spoke of the importance of this value to their work as administrators.

The really big decisions that you make are people decisions....It's really the relationships that you develop with people that are going to make the difference in the long run for whether you enhance your program or not....I see my primary role as leader of
oncology nursing programs. I believe that if I can help each one of the people in the program be successful at what they do then the whole program will be successful. That's my goal - to find out what their strengths are and to capitalize on [those strengths] and give them the things that they'll succeed at....I think it's really my basic belief about people, is that people want to do a good job, they want to do the best thing they can. That people who are in management positions want to provide good care - they may not know how, they may not have the structure in place, but basically I believe that until someone indicates differently and there are very few people that indicate differently. (Jackie)

The belief in people drives ways in which the participants choose to manage and lead subordinates. Trusting in the capabilities of their subordinates, these administrators delegate and empower them, using the full capacities of the subordinate to benefit the organization.

I think I run a very participative management [style], that my style is to hire the best people that I can find, to give them a very clear challenge and then let them do it. Letting them know that I'll reel them in from time-to-time to see how they're doing, or they can keep me informed, but I'm not going to check on them. I don't ask people what they do every day, I don't ask staff to tell me or give me all their plans for everyday. I feel managers will come to me. If they have a problem they pop in or they call....I care about them as individuals and I care about them as professionals and I recognize that they are all different and that they come from different perspectives. (Sandra)

The administrators' belief in people was also described in actions taken or "Acts of Belief" such as that described by Sandra:

Every group here, actually every unit, every committee, [every individual manager] has to come up with annual
goals and objectives based on the department goals and objectives which are drawn from the strategic plan....Then that's their challenge, are those goals. They set their own and we review them together and then they go. Individually as part of performance appraisal they have to set goals. So that's where their challenges [come] from and I have to push some people. They've been surprised at themselves at what they can do and how well they do it. I've just seen some people really blossom and that's where I get a tremendous amount of satisfaction from.... (Sandra)

These "Acts of Belief" based on a trust in the ability of people allows the nurse administrator to develop individuals and departments for peak organizational performance.

The participants also described belief in people as a source of fulfillment and joy in their work.

I particularly like to hear about what they are doing and watch the excitement on their faces and enthusiasm when they tell me about a particular patient or something they did for a family or a new accomplishment or perhaps they're on a committee and they want to show me the results of the work they've done on this committee. Just to see the enthusiasm and excitement about being a nurse and working on their unit with their particular patient. I like to see that. (Lynn)

The belief in people which is so clearly valued by the participants and described here by Lynn, serves not only as fuel for the administrators' practice but also as a means of expressing concern for subordinates, using one-to-one interactions to validate the subordinate as a unique individual. These opportunities for mentoring and development result in subordinates' awareness of the direct effects of the administrator's belief in people.

I think they [subordinates] see me as someone who recognizes opportunities for other people and try to
promote other people through those opportunities. (Karen)

Belief in people is closely linked to humanistic perspectives. It influences how administrators have chosen to work as leaders and results in "Acts of Belief" which strive to develop subordinates for peak performance. Both a source of personal joy and fulfillment and a means of expressing concern for subordinates, Belief in People was clearly an integral component of the administrator participants' value systems.

Clinician Identity and Knowing the Clinical. These two factors are closely related but yet remain distinct. These factors emerged from the interviews of each participant (n=22). Participants described a retained sense of self as clinician and a need to know the clinical which were integral to their value systems.

The participants clearly described their core identities as that of the clinician:

I still think about clinical.... I have not made the transition [from clinician to administrator] yet. (Jackie)

I feel like I've never lost my perspective or interest in what goes on at the bedside level. (Sandra)

I'm a clinician, all of us are. (Nancy)

This identity as a clinician was described by the participants as more than a label. Retaining the clinician identity for these administrators means having ongoing
contact with patients and families.

Honesty, there were times that I would, if I was working in my office in the evening, I would go down and give backrubs at night. I needed it probably more than the patients. I have always been able to maintain interaction with patients through extensive rounds on patients' units, that kind of thing. I don't make every room all the time. I may not even make them every week. I'm up on the units interacting with the nursing staff and just sort of popping my head in for a patient or two from time to time.... (Karen)

Going back to the patient piece was more [important], I found myself gravitating to the awake patient, trying to change people's attitudes....So that's where I would go at the beginning of the day. To see patients on the way in and then definitely to [get a] 'fix' on the way out. (Diana)

The desire to retain a clinician identity is reinforced by contacts the participants have with patient.

It's interesting because even after all these years it's one of the reasons I tried to build in going to the units because occasionally...I can still connect with the patients, even though we don't even know each other. Like for one instance one gentleman started just crying and I knew him all of five minuets, so I must have a skill that I developed. To be able to make at least some people feel comfortable about talking and sharing and knowing that somebody is there to listen. (Nancy)

A couple of years ago I spent a day down in the outpatient department with one of the nurses and it's amazing how quickly and automatically you do some things and when you're interacting with patients I found it really interesting that I just really slipped into that. (Karen)

This same desire to retain contact with patients and families can clash with the realities of administrative work. The demands of the role of the administrator can make patient contact difficult to maintain.
Then when I got into this position, again it was a hard transition, and it still is, at times. I still miss patient care a lot. (Nancy)

These patient interactions seem to serve multiple purposes. The contacts reinforce the skills and abilities of the administrators as clinicians. They also allow the administrator to return to the comfort zone of her former work in clinical practice. In addition, the nature of these clinical contacts are almost exclusively interpersonal and may provide the administrator with affirmation and rewards which are slower to come from daily administration practice.

Patients will thank you, patients thank you profusely. You get letters, you get cards, you get all those kinds of things and as a manager you don't get things in the same form. (Sandra)

Patient contacts and a clinician identity also serve as a way for the administrator to bond with the staff they supervise. It is important to these participants, and to most nurse administrators, that staff know that the administrator understands the work of the clinician.

I always feel like staff thinks, "Nobody knows what I do, nobody knows how hard I work." You do because you did it and because you watch them and you see them. (Sandra)

The patient/clinical contacts validate the grounding of the participants' knowledge in clinical practice. This grounding is viewed by the participants as necessary for them to be effective in their roles. It is elegantly described by Sandra as being "Rooted in the Real":

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I think my knowledge base is more rooted in the real....They [non-nurse administrators] don't see how the pieces come together and I've noticed this more now that I have services beyond nursing. I see how other administrators had those non-nursing services. They treated them differently than I treat them now. I see myself as more practical, more rooted in the real. I feel I'm more creative and that may be my own personality more than the nursing leadership role, but it's just like nursing. Nurses are problem solvers.

The reality focus of the participants in combination with a clinician identity results in an expressed need to "Know the Clinical" as described by Jackie in this paradigm case:

I not only have to rely on what the experts or clinical nurse specialist has told me, but I have to have a framework for evaluating the information. I feel like I need to know that. I may not need all the details, but I need to know what a patient who has an allogeneic [bone marrow] transplant goes through, more than just a cursory review of what they go through and what they suffer, to achieve that [desired] outcome, because I'm the one that's going to make the decision about the nursing care they receive, so I need to know that. I can't function without that knowledge. I can't....If I remove myself from what the whole product is, the outcome, which is the best possible patient care we can give, if I remove myself from the clinical aspect, then I can't help achieve that. I can't help the staff who actually are the ones who achieve it. I can't help them get there. I've watched other people who are directors of clinical areas and if you don't have the clinical part you can't lead. You can perhaps manage the area and then you can take care of all the [basic] stuff, the time sheets, all those things that are not the perks in the job for me. You have no way to put anything into perspective or weigh what's important and what isn't. You don't know what to keep and what's left over. You can't help your advanced practice people move ahead, you can't help your nurse managers move ahead. It's very important to me to have nurse managers who are grounded clinically. Doesn't mean they have to be expert clinicians but they have to know what it's like to provide care to an oncology patient.

The nurse administrator 'knowing' of the clinical components
of patient care is viewed as an asset for effective leadership which gives nurse administrators a competitive edge in their ability to make decisions. This asset is summarized by Lynn as she describes her perception of nurse administrators bringing unique skills to their practice:

I think probably the biggest difference is the true understanding of the clinical side and the clinical piece and I don't mean that every nurse administrator knows all the ins and outs of the clinical area that she oversees; but she has the ability to listen and at least to be able to interpret what's happening I think a lot quicker and probably a lot closer to the truth than perhaps a non-nursing administrator could.

The clinician identity is supported and retained as a result of ongoing contact with patients and families. This contact, which can be difficult to maintain in the face of job demands, reinforces the skills, abilities, and identity of the administrators as clinicians. The contacts also may provide the administrator with affirmation and rewards which are slower to come from daily administration practice and assist the administrator in helping the staff to know that the administrator understands the work of the clinician. Clinical grounding is viewed by the participants as necessary for them to be effective in their roles. The participants' grounding in reality, when linked with a clinician identity results in an expressed need to "Know the Clinical". Together these factors become an asset for effective leadership which gives nurse administrators a competitive edge in their ability to make decisions.
**Patient Focus.** The final factor entering the pattern of this theme is that of Patient Focus. Patient Focus emerged from every interview (n=17) with the factor flowing directly with and from the participants' values of knowing the clinical, belief in people and humanistic-altruistic values.

The blending of a patient focus and humanistic-altruistic values is described in the following example of how clinical experiences early on in her career shaped this participant's development of a value system.

The patients. Being able to talk to the patients. I think probably more than anything else it helped me personally. I truly appreciate the full dimension of the human spirit that I hadn't had. Once I was able to have that feeling there was nothing that compared to it. I liked a lot of things about it. (Jackie)

The influence of this value in Jackie's later work as an administrator is clear:

The most important thing for me is [that] the decisions I make are based on two things and it's always been that way. It's what's going to be best for the patients, number one and what's going to be best for employees. If I can combine the two, Great. And if I'm within an organization that doesn't value that or doesn't listen to me speak to that then I'm not going to be with that organization. I'm just not going to compromise it. I never will. I have to live with myself.

The patient focus of the participants also stems from their belief in people as illustrated in the following:

Yes, it's rewarding [the knowledge that patient care is being delivered]. It makes your life that it's still there even though you may not be in the thick of it. Everyday it's still happening upstairs and on the
floors and that's real good. That [makes you feel] real confident. (Lynn)

Patients still come first and I try to make all my decisions based on what's in the best interest of patient care. I've always found that it takes it enough out of the political arena and that we can generally reach consensus on something that's in the patient's best interest. (Karen)

The focus on patients not only provides the administrator with a touchstone for decision making, it also serves as a foundation for consensus building and a barometer for the administrator to gauge her performance.

In summary, the theme of a "Person Centered Value System Rooted in the Reality of Clinical Practice" describes how the participants view and conduct their work. The value system provides a way of maintaining perspective in a complex environment with often competing priorities. In particular, within healthcare institutions, the administrator is confronted with the seemingly competitive priorities of economics and providing for human care. The Person Centered Value System allows the administrator to reconcile these two priorities.

The clinician identity allows nurse administrators to know those aspects of patient care delivery which are essential to quality outcomes. Quality outcomes are essential to the economic survival of the organization. Maintaining a patient focus not only bases discussions and decisions on customers needs, it also provides a vehicle for
collaboration and consensus building.

Belief in People and a Humanistic-Altruistic perspective permit the nurse administrator to accomplish several objectives. As subordinates sense the interest, concern, kindness and candor of the nurse administrator, they begin to allow a relationship which will assist them in personal and professional development. Likewise, the administrator who effectively communicates concern for subordinates as unique individuals will engage in activities such as delegation and team building. Focusing on, understanding, and empowering subordinates will lead to their actualization. This in turn will allow maximum benefit to the organization. Far from being mere courtesy, effective social skill or benevolence, Belief in People and Humanistic-Altruistic factors are essential for the "most powerful influences [which] consist of deeply human relationships in which two or more persons engage with one another" (Burns, 1978, p. 11). The cultivation of these human relationships when combined with clinical knowledge and patient focus can result in moral leadership which "emerges from and returns to, the fundamental needs, aspirations and values of the followers" (Burns, 1978,p.4). The administrator engages in behaviors which are driven by the belief in people and humanistic-altruistic value systems.
Regarding Theme 1, a Person Centered Value System
Rooted in the Reality of Clinical Practice, the literature is supported in the following areas.

The ability to retain clinical contact and identity was a common theme found in the study of excellent nurse administrators. Nyberg (1989) spoke of the importance of nurse administrators retaining clinical contact and knowledge and the need for them to be able to prioritize and order life activities to allow this to occur. Dunham and Fisher (1990) described the significance of nurse administrator clinical rounds. In this study of excellent nurse administrators, the participants described their love for making rounds, including seeing patients. The clinical contact kept the administrators "energized and motivated" (p. 5) and contributed to their strength and effectiveness as leaders. Clinical contact and competence as described by the participants in this study are also characteristics valued by staff subordinates in a 1990 study by Meighan. That study, in which staff nurses identified the most important characteristics of nurse leaders, reported that an overwhelming majority of staff valued clinical competence. Thus, the ability of all the study participants to characterize the significance of "knowing the clinical" advances the earlier assertions by Nyberg, Meighan and Dunham & Fisher.
The findings of this study related to patient focus, clinician identity and knowing the clinical support the "Knowing" component of Swanson's (1993) structure of caring. Knowing is defined by Swanson as the "anchor that moors the beliefs of nurses to the lived realities of those served. Knowing is striving to understand events as they have meaning in the life of the other" (p. 355). The voices of the administrator participants in this study give support to this theory of caring. Knowing the clinical ties the beliefs of the administrators to the realities of the subordinates they serve.

Finally, Lipman-Blumen's Connective Leadership Model (1992) describes leadership behaviors as belonging to different types of "achieving styles" or ways of getting things done. The findings of this study lend support to the presence of Lipman-Blumen's two achieving styles in the leadership of nurse administrators: Instrumental and Relational styles. The participants' descriptions of Humanistic-Altruistic values and a strong belief in people are both consistent with Instrumental and Relational styles. The nurse administrator participants in this study gave rich descriptions of their instrumental styles; they described importance of connecting with subordinates emotionally and establishing strong relationships with them. The participants also gave descriptions of their belief in
others which are consistent with the "entrusting instrumental" styles described by Lipman-Blumen (1992). The participants speak to their belief in, relying on and entrusting others with their vision. Several of the interview texts reviewed earlier in this chapter described the processes the participants used to entrust and empower their subordinates.

The Relational Achieving style in Lipman-Blumen's (1992) model was evidenced in the many descriptions given by the participants in this study which describe the satisfaction they derived from seeing subordinates be successful. Descriptions of the rewards participants experienced as a consequence of their belief in people. The theme of a Person Centered Value System gives strong support to Lipman-Blumen's model of Connective Leadership.

The Person Centered Value System supports several additional works on leadership. Ray's (1989) explanation of the Theory of Bureaucratic Caring reported empathy, communication and rapport were descriptors used by nurse administrators to describe caring in their practice. Hatcher (1991) operationalized transformational leadership stating that these leaders understand, accept and value each member of the team as an individual (p. 73); that they create a sense of connectedness with others, a sense of intimacy and emotional warmth (p. 78). The administrators

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in this study affirm the importance of these leadership attributes through their descriptions of humanistic belief in people.

Finally, Kahn (1993), in a study of patterns of organizational caregiving, identified specific "Acts of Caregiving". These acts or behavioral dimensions include two which are supported by the theme of Person Centered Value System in this dissertation. Specifically, Kahn's dimensions of Validation and Compassion mirror Belief in People and Humanistic-Altruistic values. Validation speaks to communicating positive regard, respect, and appreciation of others, while Compassion is about those behaviors which show emotional presence by displaying kindness, warmth and affection. These dimensions are clearly discerned in the interview data of this study.

**Theme 2—Courage and Sensitivity in Decision Making**

The emphasis participants placed on a humanistic belief in people does not, as some might speculate, generate impotence in administrator decision making. Far from impotent, the participants described multiple instances in which they made very difficult decisions. The codes which contributed to this theme included three caring factors totalling 103 coding instances: Sensitivity to One’s Self and Others (n=43), Faith and Hope (n=31), Development of Helping–Trusting Relationships (n=29). Two leadership
factors (n=82) were related to this theme: Courageous (n=54) and Ability to Handle Complexity, Ambiguity, and Uncertainty (n=28). A third factor, Tough/Painful Decisions (n=8), emerged from the interview data in predictable pattern relationships with the previously mentioned factors.

The participants described their ability to be sensitive to the impact and effects of their leadership practice. They talked about tough and painful decisions which were made with courage and sensitivity, while attempting to sustain relationships and help subordinates through the trauma resulting from some of the decisions. The participants spoke of their efforts to assist subordinates in seeing the larger context within which decisions are made and how the subordinates fit into that context. There are remarkable descriptions of the participants' ability to use their sensitivity to master the complexity of the organization. Finally, there are powerful examples of participants' "Acts of Courage" in which participants describe actions taken which were based on values and vision. These actions were taken, at times, in spite of resistance.

**Sensitivity to One's Self and Others.** This caring factor, according to Watson, allows the self to recognize and appreciate emotions. Through the sensing and acceptance of the emotions of clients, the nurse mirrors these feelings
back to the client, facilitating the client recognition of
and ability to manage them. The interview data give clear
evidence of examples in which nurse administrators use
sensitivity in their practice to serve clients. However,
their clients are subordinates, colleagues or the
organization. In these examples of Sensitivity the
participants describe how they detect the feelings, the
milieu, within the organization and then effectively reflect
these back in a way which allows for insight and action.
Sandra discusses sensitivity in this paradigm:

In nursing there's a sensitivity that is at all levels
that I don't think is there in other departments....I
think that sensitivity is a very important part of
caring. It's like you always [have] the feeling of
vibrations and you can tell when somebody is in
trouble, even if they don't want you to know that
they're in trouble, you just know. Somebody will come
by and I'll just look at their face, I'll look at the
way they walk, I'll look at how they behaved in their
meeting, and then I'll know - and I'll say "I've got to
see what's going on". Then I can say [to them] "How are
things? You looked a little pale." or "You were pretty
quiet today". I see nurses taking care of one another
in this way. They just have this sensitivity to the
vibrations. I don't sense that [in other departments].
I mean I think you would have to come in crippled for
some other departments to recognize that there's some
change or that something's bothering you.

The administrator participants all described aspects of
sensitivity in their practice.

I think I spend a little more time in talking with
nurse managers and really trying to get where they're
at with stuff and how they feel about it even if they
don't have a choice in what the outcome is. How they
feel about it is important to me because it gives me an
idea of what I need to do to help them feel better
about what they have to do. (Jackie)
I particularly like to hear about what they [the staff] are doing and watch the excitement on their faces and enthusiasm when they tell me about a particular patient or something they did for a family...just to see the enthusiasm and excitedness about being a nurse...I like to see that. (Lynn)

Sensitivity to self and others allows the nurse administrator to promote wellness (success) in others. In the process of sensing and accepting the emotions of the other, the administrator experiences them empathically.

The participants speak about this sensitivity as intuitive, following a sense, a hunch, and being very much like their experiences of Sensitivity with patients. They relate how they have taken their clinical experiences a step further into their practice as administrators. Lynn talked about some of her clinical experiences with patients which were indicative of sensitivity.

I think it [caring] looked like having good listening skills and taking the time to read your patients, to see their faces and facial expressions. To make sure that what they were saying matched their body expressions and their facial expressions. Knowing that they may be struggling with something and that maybe you needed to spend a little more time with them.

Later in the interview, Lynn was asked to describe some examples of interactions with subordinates. In her description there emerged a clear parallel to the work she described with patients.

I think just to be able to read that they're stressed to the max or learning their body language and being able to see when perhaps I'm requesting something of them that is beyond their ability to carry out at that time. Most recently...in the midst of many other
changes on a unit I could see that additional possibility [for more changes] was the straw that broke the camel's back for the unit director...I can see it in her face and in her reaction to even the slightest possibility of that occurring.

Another parallel between the clinician and the administrator experiences of Sensitivity was described by Sandra.

Sensitivity is that stuff that we read from patients that you can [use to] just say "This patient is getting into trouble even though their vital signs don't show it yet". I think nurses are very sensitive...and I think that good managers are sensitive to changes in their staff. I think sensitivity is a key ingredient.

The sensitivity of the administrators allowed them to execute specific interventions directed at subordinate (client) recognition of and ability to manage feelings. For example, the ability of the administrator to be sensitive to their subordinates in times of rapid organizational change can lead to understanding and the facilitation of the change process. This is illustrated in the following description by Nancy.

Perhaps there are issues where [the subordinate managers] feel like their voices have been heard but have not yet been totally followed through. [In that situation] as long as I can explain and justify why some decision has been made they can understand what is going on even though they might not agree with it. Maybe taking into consideration that you don't just drop everything to bare bones just because the cost issues or FTE constraints are here; actually juggling all the factors as well as the gut feel that you have for how things are going.

The ability of this administrator to use sensitivity to reflect feelings back to subordinates can ease the transition of a difficult decision. Sensitivity also allows
this administrator to exert influence within the organization based on the insight she has gained from her subordinates and herself.

Sensitivity is closely related to the next factor to be discussed - Ability to Handle Complexity, Ambiguity and Uncertainty. However, where sensitivity was more likely to be found in instances of administrator work with individuals or groups, ability is described in relationship to groups and departments within the organization.

*Ability to Handle Complexity, Ambiguity and Uncertainty.* This factor is reflective of the leader's mastery of the social, technical, and political aspects of the organization. The participants' mastery of the technical, clinical aspects of the organization were discussed in depth in Theme 1. In Theme 2, the focus of the discussion is on the social and political aspects of the organization, although some examples of the participants' technical/clinical mastery will be evident.

In several of the interviews, the participants explicitly discussed their views on the significance of this factor in the work of the administrator. They speak of this characteristic as being essential for the provision of guidance and direction to their subordinates. The mastery of the social, political, and technical aspects are also viewed as a means for influencing the organization.
Trying to set the direction, that's a value to me.... I need to make sure that I understand what's going on externally as well as internally that influences the direction [I set]. So that if we look like we're getting to far afield I can get us examples of where we need to be. (Karen)

I find nurses just as territorial as everybody else. It's the medical versus the surgical nurses; the "My nurses work harder than your nurses". There can be an awful lot of that stuff. They don't understand each other's roles...I think that's probably the most difficult part for the executive is trying to keep the free flow of information and getting people to talk to each other and understand. (Diana)

I think it's really important as a manager or administrator to have a feel for where the folds of the organization are and where it's going. What I value in a leader is somebody that thinks of all the various pieces and puts [departments] or sections or people in place to try and cover all the bases....As a leader I think you also have to interact with a variety of people - some that you don't always respect and some that...are difficult. But as a leader you have to come above all that and be able to share in collaborating in instances where you don't always agree with them. (Nancy)

The ability to handle the complexity of a health care organization was described positively by Diana. In this excerpt she gives a clear example of the skills of the nurse administrator in mastering the social, technical and political aspects of the organization.

I saw the overall cuts and if you're going to cut social work you are [in essence] cutting nursing. So I'm on the phone with the director of social work. I look at the pharmacy cuts [and think] "This is craziness! You cut pharmacy, you hurt nursing." The recommendation was to cut respiratory therapy and [I ask] "Who's going to pick up that workload? Nursing?" I was told the nursing assistants can do some of this. I'm sure they can, but who is going to look at their workload? Not until the housekeepers make beds.
Sandra gave another description of the nurse administrator's effectiveness in providing direction that is a result of her mastery of the many aspects of the organization. Her skills allow her to make significant contributions in an organization which is undergoing financial pressures and rapid change.

I don't think the current budget stuff and changes are going to prevent us from reaching our ideal. I really don't. I feel it's a pain in the neck and it's scary, but I think it's going to make us do things in different ways....Now I find administration much more open to cross-function things than in the past and I have created a clinical operations committee that [involves every clinical department]. They didn't meet before. (Sandra)

**Tough/Painful Decisions.** The presence of Sensitivity and the Ability to Handle Complexity, Ambiguity and Uncertainty contribute to the ability of the participants to make tough decisions that are not without pain. The pain arises from the administrators' awareness and sensitivity to the effects of the decision from a humanistic perspective. The participants describe examples of these decisions, relating the courage required to do the 'right thing' while confronting the effects of the decision on people. Jackie describes some of her experiences in holding managers accountable to standards.

What I initially saw was not that the nurse managers weren't effective. What I initially saw was that the care was very substandard and then when you trace that back to what the issues are...you look and it stops here at the nurse manager....Then I had to decide how much time; is this situation salvageable or do we need
to move ahead. Some tough decisions....The managers
needed to come half-way; they needed to make that
effort and if they couldn't then they either resigned
or in some instances they relocated or whatever. Some
of those were very, very painful decisions to make
because some of the people have been in positions for
very long periods of time.

There were additional descriptions of the ability of the
participants to make difficult decisions, knowing the
effects on subordinates.

We just had a very, very traumatic experience here...in
that we had to disband [close] a nursing unit and
nurses that had worked together for fifteen years were
spread out among other nursing units. It was very
traumatic; very, very traumatic for the organization.
(Karen)

We got after the patient satisfaction surveys with a
vengeance. They're positive but I want them more
positive....I have little tolerance for people who are
abrupt with patients or who have problems in dealing
with them. I will really push them [staff] into the
support services that are available or get them out of
the environment, take leave, do whatever you have to
do, but move along. (Diana)

In both instances the participants were able to
identify the necessity of making the decisions while at the
same time maintaining an awareness of the human costs of the
decision. They provided subordinates with support in coping
or served as a mirror to reflect into the organization the
pain experienced by its staff.

Faith & Hope and Development of Helping-Trusting
Relationships. The participants also spoke of efforts
specifically directed toward others which were designed to
solidify team relationships and ease the many transitions
within the organization. These efforts were strategies employed by the participants with definite outcomes in mind; most often the outcomes were related to decisions made and managing the resultant change from that decision. The capability of the participants to nurture and instill faith and hope in others encourages the expression of beliefs and values. These beliefs and values in turn influence the ability of the individual/group to see the larger context of the organization and how they might fit into that context. The individual/group begins to have faith and hope in something beyond themselves. Accomplishing this process of promoting the "big picture" perspective is dependent upon the administrator having developed relationships with others which have their basis in trust and mutual respect. There were several examples within the interview data where the participants spoke directly about their efforts in these areas.

In my first month here I just kind of met with people and heard all [the viewpoints] and realized that there was no way I could possibly deal with all this history and make it better. I kept thinking about how I was going to bring all these people together so that we could move ahead. I decided that the one thing we could do to pull people together is to identify those things that we agreed on, not what we disagreed on, and to move ahead. Out of that came the strategic plan. (Jackie)

I think that my biggest job is to help create a clear vision, and we still have some rough edges on our vision, so I'm not there yet. The team building project has been a tremendous help in building the trust, in building more open communication, and those
are the tools I think we need to get closer to the ideal. (Sandra)

Hopefully [the effects of my interactions with my subordinates] are greater satisfaction in the work that they are doing. That they know there's somebody else who can empathize when they're overwhelmed and that feeling of being overwhelmed doesn't mean they're not good at what they do or not cut out for that position. I think it gives them greater satisfaction in their work and also the ability to communicate with me. (Lynn)

The participants articulately recounted their actions in developing and sustaining relationships based on faith/hope and help/trust. These actions are further seen in association with participant examples of courageous characteristics of the nurse administrator.

Courageous. The courageous leader is one who has the ability to espouse a position based on values both to those who do and do not want to hear the position. Courageous actions, here called "Acts of Courage", occur when the leader takes actions which are grounded in beliefs and values; sometimes in the face of opposition. The participants gave multiple illustrations of instances in which courage was necessary for them to have been able to take the actions, make decisions or institute the changes described. Some of these Acts of Courage describe obligations felt by the participants to actualize support which has been committed to others.

I think [being a leader by action] means not just saying that you'll support them [subordinates] but by actually providing that support. Maybe participating
in something that you know is very important to them
even if it is just being present, or by supporting them
financially or any way that you can. It seems at least
for me, to make a difference. (Lynn)

As a leader I think you need to provide the resources
to be able to make happen whatever it is that you
value. So for instance, I value obtaining respect for
the care provided here and the nurses who provide it.
So I try to provide opportunities for others to be able
to publish and present and be visible in terms of what
they have to offer. (Nancy)

Other instances of courageous acts described actions
taken by participants which were based on their patient
focused values.

We designed a program to meet the family needs [of
surgical patients]. I took two nurses who were
interested in doing this role and said "Go ahead and
develop it", and took them out of the operating room.
That I dare take good OR nurses out of the operating
room! I have had to justify that for I don't know how
long! I also have a critical care area that would like
to get rid of the family lounge right outside of
critical care. They want the space and suggested we
could move those people [families] down to the lobby.
I said "On one condition - you open your visiting hours
so that they can come in at any time". They said
"Absolutely not!", I said "I guess we're not going to
move the lounge". (Diana)

The most compelling of the participant descriptions of
Acts of Courage are those which deal with their awareness of
the human impact of decisions. Through these interview
excerpts the sensitivity and courage applied in participant
decision making radiates through the words.

Up until recently we hadn't lost money, but with the
decrease in [patient] length of stay we just had to
close our first [nursing] unit. The focus for me was
to make sure that I absorbed everyone that I could, and
I did, I absorbed everybody. That was a promise to staff that we would do that. (Diana)

Last year we had a spiritual retreat. I felt that was a caring thing we could do for one another. I wasn't sure how it was going to go over with [upper] management. I explained to [the CEO] that I felt these were nurses who gave and gave and gave and I was concerned that there wasn't going to be any more for them to give if they didn't get to replenish. And that's what our retreat was, "Women At the Well"; it was designed for these people to replenish themselves. And it was fine with him [CEO]. (Sandra)

With many of the restructuring activities that institutions are experiencing today, we have people who are losing their positions. I have been impressed with the nursing leadership in that no one has ever forgotten a person who is being displaced....We truly focus on that person and work through this life experience with them so that the person doesn't feel like a failure, that they know this is just a fallout from what is happening all over healthcare. (Lynn)

In possibly the most poignant description of Acts of Courage, Diana talks about her efforts to care for colleagues in an institution that has economic limitations. In a financially constrained environment Diana acknowledges the significance of sensitivity to others and of promoting faith and hope in something beyond the individual themselves. She provides continued meaning in the lives of these subordinates by supporting them in their work. She speaks, perhaps ironically, of cancer nurses caring for nurses with cancer.

One of my subordinate managers developed metastatic breast cancer. A year after this diagnosis she is still hanging on for everything that's out there. And [she says] "Diana, I want to work, I have to work, I want to work". So I'll support her in whatever [way I can] to allow her to do that. We had a nurse who just
died from ovarian cancer. We carried her for about four years. All she wanted [was to finish her nurse practitioner program] and she was doing so well as a nurse practitioner. Then she had a recurrence and died.

In summary, the theme of "Courage and Sensitivity in Decision Making" describes the processes by which nurse administrators make and implement decisions. The participants often spoke of their ability to recognize the human impacts of decisions which were about to be or had been made. This sensitivity applied both to decisions made within the purview of the administrator as well as decisions made by others. In either instance, nurse administrators are capable of sensing the outcomes of the decisions from the perspective of the client: the subordinate, department, and organization. This recognition, or sensitivity is followed by a reflecting back to the client of those outcomes detected. The ultimate goal of this action is to foster recognition of and the ability to deal with the outcomes. Nurse administrators also are sensitive to the complexities and ambiguities of the organization. This ability is a result of the nurse administrators' mastery of the social, technical and political aspects of the organization. Organizational sensitivity is one way in which the nurse administrator promotes strategic thinking in others, enhancing their awareness of problems and solutions.

Decision making in its full perspective includes
implementation. The interview narratives exhibited the nurse administrators' use of two strategies with subordinates related to decision implementation: developing helping-trusting relationships and the fostering of faith and hope. The goals of these interventions were to communicate to the subordinate a high regard for their experiences; this in turn allows the administrator to assist the subordinate in having faith and hope in something beyond themselves. This is of particular urgency in health care institutions in which decisions driven by economic concerns have impact in human terms; for example the closing of nursing units and reassignment of staff. In these instances it is important that the affected subordinate avoid feelings of failure and instead develop a sense of being a contributor to a larger, organizational good. The interview narratives demonstrate time and again the work of the skilled nurse administrator in supporting the individual and the organization through these decisions.

The interview narratives were also demonstrative of the courage present in the leadership of nurse administrators. Decisions, even tough and painful decisions, are made when they must be made. The nurse administrator, while sensitive to the human impact of the decision, takes action based on values and vision. The administrator participants describe courage in the form of risk-taking, advocacy, and
compassion. The nurse administrator is able to blend sensitivity and courage with the ability to foster faith and hope in ways which allow the execution of difficult, sometimes painful, decisions which need to be made.

Four categories in the literature which emerged and are supported by this theme are: courageous action, sensitivity and using faith/hope to create stability, and political abilities. The ability to act courageously was identified as a quality of the excellent nurse administrator by Pederson (1993), Dunham and Fisher (1990), Meighan (1990), Nyberg (1989, 1990) and Hatcher (1991). The words used by the participants in this study to describe courage echoed those found in the literature: advocates, keep promises, doing what you say you will do, desire to make values real, risk taking. All relate to the courage of the nurse administrator in preserving human caring in times of economic pressures.

Sensitivity and the use of faith/hope to create stability were also identified by several studies including those by Nyberg (1989), Dunham and Fisher (1990), Noddings (1984), Hatcher (1991), Kahn (1993), Lipman-Blumen (1992), and Burns (1978). In each of these cited references, as in the interview narratives of this study, the excellent nurse administrator as leader works with others to develop
relationships and accomplish goals. The leader appreciates how human relationships can offset the rigidity and seeming insensitivity of the organizational structure. Using empathy, these nurse leaders put themselves in the other's experience, identifying and feeling with them, but not for them. The provision of a steady stream of resources, compassion and support results in the subordinates' trusting that their own needs will be met and that they are part of a larger effort. Alignment and connection to the organization's values are an important consequence of these leader actions.

There are strong similarities between the ability to handle complexity, ambiguity and uncertainty identified in the interview data and the political abilities identified in the literature. Pederson (1993), Lipman-Blumen (1992), and Nyberg (1989) all describe skillful leaders as having political abilities through which the leader was viewed as powerful and capable of influencing both systems and people of the organization. These abilities also include translating to subordinates the organizational vision and values; quickly identifying and focusing on the individuals and groups the leader must work with and influence; and possessing a political savvy through which the leader understands relationships and networks as vital and legitimate conduits for accomplishing goals. These
political abilities were all found to be present in the interview data of the participants in this study.

The theme of Courage and Sensitivity in Decision Making as described by the participants in this study is echoed in the work of Burns in which he describes transformational leaders as those who are able to alter, shape and elevate the motives, values and goals of followers so that whatever their separate interests may be, the leader and follower are coupled in the quest for higher goals. The realization of this quest is verified by the achievement of significant change representing the collective interests of both leaders and followers (1978, p. 425).

**Theme 3 - The Intentional Cascading Effect of Caring Leadership.** The third and final theme arising from the interview narratives results from recurring patterns among the code factors *Trickle Down Effect of Leadership* (n=23), *Visionaries* (n=25), *Early Experiences* (n=26), and *Providing a Supportive, Protective &/or Corrective Mental, Physical Societal and Spiritual Environment* (n=37) - hereafter referred to as Providing Environments. In total these factors were coded 111 times throughout the interview transcripts. The study participants spoke about their intentional efforts designed to influence the caring experienced by patients at the bedside. These descriptions acknowledged the inability of the administrators themselves
to personally provide this caring to each individual patient. The participants recounted efforts taken to provide caring environments for subordinates, believing that it is through the provision of these environments that the caring of the leader can trickle down through staff to the patients. Early experiences of the participants provided them with examples of ways in which they could provide caring environments. These early experiences also contributed to the participants' belief that they could influence patient outcomes indirectly, through subordinates, via a cascading or trickle down effect. Finally, the leadership abilities of the participants allowed them to make their visions meaningful to subordinates. It is through the actualization of these visions that the realities of caring are experienced by patients.

Visionaries Providing Environments—Early Experiences. Visionary leaders have the ability to develop an image of the future and its possibilities. They then make the vision meaningful to others so that it becomes shared and actualized. The participants in this study articulated clear visions as well as their beliefs about translating the vision into reality through their subordinates. There were examples of early experiences in their careers which helped to shape their later visions as administrators. Jackie specifically addresses her views on visions and being a
visionary in the following passage:

I have a very clear idea of where I want oncology [at this institution] to go. My people tell me that frequently. In other words, I have a very clear idea of how I want oncology nursing to be practiced here. So from a visionary standpoint...I do have a clear idea of what I want to achieve....I think the leadership group I have know very much that I care about them individually and as a group and I'm committed to moving the program ahead and I think they have a great deal of respect for that....I'm always focused on what we want to achieve. I'm probably the one who asks that question more than anyone else here: "What do we want to achieve by this? Where are we going with it?" If we don't know that, we're not going to know how to get there.

In some instances the participants expressed their recollection of experiences which occurred early in their careers and later influenced their perspectives on the significance of being visionary - feeling connected to an image of future possibilities. They learned as novice clinicians of the importance of feeling part of a larger effort as described here by Karen:

I saw nurses doing phenomenal things to make differences in patient care and that they really were involved....I guess that you were just made to believe that you were in a place where big things, important things were happening for patient care.

This experience for Karen encouraged her actions later in her career as described here.

I [have] always felt fortunate as a nurse because I could always do something for a patient. I always felt that even if it was a word that I could say or by some act of manipulating the environment...having patients know that they were cared about as individuals is very important to me and my practice. I worked not only individually with patients but also worked very hard to establish that kind of relationship with other care
providers so that patients got the same experience from
other people.

In these examples the effects of having been exposed to and
feeling a part of a larger vision in which she was a
participant in important things for patient care were
realized later as Karen sought to impart her vision for
patient care to others. She worked to influence patient
outcomes by interacting with colleagues in the same way she
wanted them to interact with patients. She provided an
environment in which she cared for colleagues who could in
turn care for patients.

The participants also related their perspectives on
providing environments which enable the accomplishment of
visions. There were descriptions of the obligations of the
nurse administrator to support subordinates in their
attempts to realize a vision. Several specific examples of
this perspective follow:

Basically [the managers] want what's best, want to be
successful and want the right things to be in place.
They need to have my administrative support and I see
my job as providing it. (Jackie)

When I took [this position] my thought was that I was
going to turn this into the direction that I would have
loved to have had it in when I was a staff nurse. [I]
really wanted a whole lot more support. I wanted a
direction for staff nursing. (Diana)
The Trickle Down Effect of Leadership—Early Experiences. The participants were able to recall multiple instances throughout their careers in which they witnessed the indirect, or trickle down effects of nursing practice. In fact, one of the participants labeled this phenomenon as a trickle down effect. Repeatedly, participants would describe early career experiences in which they had influenced or been influenced by another in a way that allowed them to see the potential for accomplishing goals through others. Karen described this experience as follows:

I think it was the interaction with the other nurses who were excellent role models interested in helping a novice nurse develop. When there were things that I saw that didn't meet my expectations I always spoke to someone about it....I think I was really very fortunate that I had that experience early that really shaped my approach to patients because I always worked with other people who were patient advocates...those early experiences clearly shaped me...we all rallied around to do whatever we needed to do to work on behalf of the patient.

The Intentional Cascading Effect of Caring Leadership was clearly evident in every participant interview. The clarity and conviction with which the participants described this phenomenon is remarkable. In each instance the participants discussed their work of influencing patient outcomes through subordinates; the administrators provided a caring environment for subordinate managers who in turn cared for staff nurses; the staff in turn care for the patient, realizing the goal of the nurse administrators.
The participants' words convey both the simplicity and complexity of this leadership effect.

I believe nurse managers want to provide the best care possible; they want their staff to be great to do that. They know in order to get that their staff has to be cohesive and there has to be enough staff....So that's where I see my role as helping them be successful if you will. (Jackie)

It's sort of like watching your child parent. You watch managers manage their staff and you just see your own behaviors being passed on. I find that just tremendously [rewarding]. (Sandra)

They're (managers) incredible advocates I think, empowering particularly with the clinician level. I've been trying to empower a lot at the management level and the [managers] that begin to see that they can make a change really are way out ahead. (Diana)

I'm hopefully a leader by action and by role modeling. A leader that allows my direct reports to take risk and be somewhat experimental and use those opportunities to grow and develop....I hope that I allow each individual to be creative and learn what works for them and staff and then use that [with staff]. (Lynn)

I think there are two types of [administrator] caring: caring for the staff and [caring] for the patients through my position. As far as the staff is concerned I believe they get a sense of my caring by my interactions with them....I certainly want them to know that it is important that they have the resources that they need to do the work that they do, and that I really value the work they do and I value them.... (Karen)

I guess one of the reasons I took this job is that I could have a bigger impact. That it wouldn't just be me as a role model, [that] maybe some of my [subordinates] would also have these caring factors and be able to take that down to the staff as well as to patients and families and have a wider impact. (Nancy)

In each of these instances the participants talk about their
work of creating a culture of caring. Lynn summarizes this difficult but necessary work of the nurse administrator:

I think [my work] trickles down. How the administrator functions will influence how the direct reports [function] and that influences what gets carried out at the staff level, and the staff are in there working with the patients. I would think it clearly trickles down. If I'm uncaring about the people that report to me I think it's going to be experienced all the way down the chain.

In summary, from the interview narratives it is clear that the nurse administrator as leader has responsibility to generate and make meaningful a vision of possibilities. Developing and communicating an image of the future to subordinates allows the nurse administrator to achieve a broad realm of influence. By entering into caring relationships with subordinates the nurse administrator learns of their needs, wants, and aspirations and joins these with the vision of the administrator and the organization. The result is a shared vision held by the leader and the followers.

The fulfillment of a shared vision is contingent upon the administrator's ability to provide supportive environments within which the vision becomes a reality. Providing the appropriate environment includes efforts directed toward the physical, mental, organizational, and spiritual components or attributes necessary for subordinates and colleagues to actualize the shared vision.
This can be manifest by something as tangible as making sure supplies are available to something less obvious such as providing opportunities for subordinates to take risks and succeed.

Within the profession of nursing there exists a shared vision regarding caring for patients. As discussed previously, nurse administrators have a patient centered focus and a humanistic-altruistic system of values. They retain as their primary concern the provision of a caring environment within which the health care needs of patients are met. The participants in this study described early professional experiences in which they were exposed to the concept of indirectly accomplishing work through others. This concept was carried into their practice as nurse administrators. Indeed, one definition of management is getting work done through other people. However the cascading effect of caring leadership encompasses more than simply getting the job done.

The efforts recounted in the interview narratives describe the participants' desire to influence the patient experience of caring in its broadest sense - the emotional and spiritual components as well as the physical and technical. These participants described deliberate efforts to interact with subordinates using the same caring the administrator wished to see realized at the patient level -
the intentional cascading effect of caring leadership.

Regarding theme 3 - the cascading effect - the literature both supports and is supported by this theme. Literature devoted to the study of leadership has identified a cascade effect of leader efforts. Having a clear vision, empowering staff through motivation, entrusting them with the vision, and making the vision real through others were leader actions identified in these interview narratives and in the literature by Dunham and Fisher (1990), Lipman-Blumen (1992), and Nyberg, (1989). Hatcher (1991) described transformational leaders creating environments for personal growth and fulfillment, thereby assisting the process of subordinates realizing the vision. The provision of an environment supportive of the vision was identified by the participants in this study and echoed by Hatcher as a priority: "As a leader our state of being is our primary tool; The leader must desire to put it first, to make it a priority" (p. 70).

The participants' belief that the nurse administrator can achieve caring for patients through leadership efforts directed at caring for subordinates is supportive of similar concepts in the literature. Excellent nurse leaders consistently model for staff those values held by the nurse administrator; the administrator in turn believes this role modeling will result in staff emulating these values when
caring for patients. As summarized by Dunham and Fisher (1990), "If you can care for the caregiver, the caregiver will then be able to care for the patient with the same set of values" (p. 3).

The concept of cascading or trickle down leadership efforts was the focus of both nursing and non-nursing studies. In both circumstances the transformational leadership behaviors of leaders were found to be present in the subordinates of those leaders. Bass, Waldman, Avolio, and Bebb (1987) tested for this phenomenon in non-nursing administrators and their subordinate managers. The findings of a cascading effect were called the "Falling Dominoes Effect" of transformational leadership. These findings were replicated with a group of nursing administrators in McDaniel and Wolf's (1992) study. In this study the nurse administrators, their management subordinates and staff all supported the cascading effect of transformational leadership. Both of these studies address leadership behaviors, not caring behaviors, however the interview narratives of participants in this study do support and build on these previous findings.

Kahn (1993) conducted a study which is closely related to the findings of this dissertation. Kahn identified a flow pattern of organizational caregiving which is very similar in concept to the theme of cascading caring.
leadership. Interestingly, Kahn does not reference any of the work by Bass et al, and seems to have arrived at separately analogous concepts. Kahn's study examined patterns of organizational caregiving between non-nurse leaders and subordinates which parallel those efforts described by the nurse administrator participants in this study. In both instances caregiving is seen to flow from superiors to subordinates. The key dimensions of caregiving identified by Kahn mirror the factors which comprise the theme of cascading caring leadership in this study. Specifically, the respondents of this study report empowering others with a vision. They provide a secure base or environment upon which the subordinate can depend, clarifying the supporting role of the leader. And leaders embrace the concept of "holding" subordinates, letting them feel remembered, cared for and about; a benevolent reconstruction of parent-child relations which acknowledges the shared ownership of goals. The expected cascading effect of caring leadership described by the participants in this study is supported by Kahn's finding that when people felt cared for by superiors they were more willing and able to pass on such caregiving.
Subordinate Perspectives: Completing the Picture

Subordinates of the nurse administrator participants provide the perspectives of those who are the recipients of leadership efforts. The subordinates from each institution were asked to complete the CAT-A survey instrument to rate their perceptions of nurse manager caring behaviors. The staff were asked to rate their immediate manager, not the administrator, while the administrator participants performed self ratings. The same CAT-A survey was completed by each administrator participant except that they performed a self rating. The mean staff score from each institution was calculated and compared to the corresponding administrator self score.
The mean staff scores were also compared among the six data sites, looking for patterns. These survey score comparisons were made for the purpose of complementing the findings from the administrator interviews; providing another perspective (Table 3).

Table 3
Total Caring Scores by Site: Administrator Self Ratings and Mean Staff Ratings of Managers

<table>
<thead>
<tr>
<th>Site</th>
<th>1 N=10</th>
<th>2 N=8</th>
<th>3 N=10</th>
<th>4 N=11</th>
<th>5 N=13</th>
<th>6 N=10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admin.</td>
<td>418</td>
<td>361</td>
<td>417</td>
<td>423</td>
<td>449</td>
<td>358</td>
</tr>
<tr>
<td>Staff Mean (±SE)</td>
<td>409.4 (11.2)</td>
<td>375.5 (24.7)</td>
<td>347.2 (22.7)</td>
<td>353.3 (12.9)</td>
<td>369.5 (15.3)</td>
<td>392.9 (11.3)</td>
</tr>
</tbody>
</table>

Note: Possible total caring score range is 94 (low caring) to 470 (high caring).

When the administrator caring self scores are compared to the staff members' mean scores of manager caring behavior, there is a clear pattern of cascading caring. The administrator self scores range from 358 to 449, with a mean of 404.3. Since the possible scores for the CAT-A range from 94 (low caring) to 470 (high caring), the overall administrator mean shows a trend toward the higher end of the scale. This is indicative of the administrators' belief that they are engaging in caring behaviors and providing caring environments for staff. The staff members' mean...
scores for manager caring behavior ranged from 347 to 409, with a mean of 374.6. While the staff scores are lower than those of the administrators', they are still well within the higher range of caring scores. This is reflective of staff perceptions of being cared for by their managers.

These findings support the third theme of cascading caring leadership. The numbers of managers organizationally placed between the administrator participants and the staff ranged from one to two. Those data sites in which there were two levels of managers between the administrator and the staff had larger differences in total caring scores between the two groups. Conversely, those sites which had the closest agreement between administrator and staff caring scores also had only one level of manager between the two groups. This finding provides additional support to the cascading effect of caring leadership: the more levels of managers through which the administrator must influence the staff, the more the dilution of the caring leadership. Each layer or level of management serves to screen out some of the effect of caring leadership.

In the literature, the cascading effect of leadership has been reported by Dunham and Klafhen (1990), McDaniel and Wolf (1992), and Bass, Waldman, Avolio and Bebb (1987). Specifically, the finding that subordinates will assign lower transformational leadership scores to managers than
the managers assign themselves, parallels the findings of this study related to caring leadership. Nyberg (1990) asked staff nurses and nurse supervisors to rate the caring of the supervisors. As found in the dyads in this dissertation, Nyberg's results revealed a cascading effect with supervisor self scores being higher than staff subordinate scores of the supervisor. The cascading effect - either of transformational leadership or of caring leadership - is a result of each successively lower follower in the organization exhibiting similar leadership qualities to the administrator, but of a lesser score.

Comparison of the staff nurses' mean scores across data sites also provides interesting information. Examination of the context of each of the organizations provides a framework for understanding the findings. Three of the total six data sites had undergone significant organizational change within the six month period prior to data collection. Some of these changes were reported in the interview narratives. Specifically, two of the organizations had closed nursing units, and one of these two was preparing to close another unit. The third organization had imposed staffing reductions and had increased the numbers of non-nurse, non-professional caregivers. The remaining three organizations, while not immune to the changing healthcare environment, had either not experienced
such drastic changes or had undergone changes in the more distant past. The three sites which had experienced the greater changes had lower mean caring scores assigned by staff nurses. The three sites which were in more stable environments had higher caring scores as rated by staff. This pattern was not observed among the administrator participant self ratings. These results present the potentially significant mediating effects of organizational changes on the subordinate perceptions of leader caring and effectiveness.

Two studies in the literature offer similar findings. Bass, Waldman, Avolio, and Bebb (1987) noted that differences found among organizations in staff assigned transformational leadership scores may be attributed to the culture of the organization. Nyberg (1990) reported higher caring scores in those institutions using higher numbers of nurses per patient. This apparent relationship/effect between organizational context and staff perceptions of caring gives nurse administrators additional challenges, specifically in the further development of skills for evaluating the staff impact of organizational change.

The application of multiple data sources and methods in this study was intended to allow for a wholeness of perspective - and a validation of the intended results of administrator self-described leadership efforts. Both of
these objectives were accomplished.

Summary

The findings of this study revealed that nurse administrators engage in leadership efforts which result in staff nurses perceiving that they are cared for and about. Administrator participants were skillful in decision making and appropriately sensitive to the staff and organizational impacts of those decisions. The participants had the capabilities to combine their mastery of the technical, social and political aspects of the organization with the capacity for developing helping-trusting relationships with subordinates and colleagues. As a result of these combined abilities, the administrators were able to impart to subordinates of sense of faith, hope and contribution to the larger goals of the organization. Administrator participants operated from a value system focused on belief in people and the importance of humanistic-altruistic values. These values resulted in staff perceptions of individual consideration, kindness and empathy; being cared for. The concluding chapter examines the challenges and opportunities suggested to nurse administrators by the findings of this study.
Chapter V

Nurse scientists and practitioners must treasure some of their nonlinearities and other unexpected results and avoid preconceptions based upon ingrained ideas. We need to move away from homogeneity of thinking and seek new breakthroughs, develop new ways of seeing the usual.

Watson (1988, p. 8)
Summary and Discussion

The overall purpose of this study was to generate an understanding and structure of the experience of caring as a component of the leadership practice of nurse administrators. Specific objectives derived from the purpose were: (a) to describe the perceptions of nurse administrators of cancer services regarding their experiences of caring within their leadership practice, (b) to uncover common elements and themes of caring and leadership in the practice of nurse administrators of cancer services, and (c) to describe the effects of caring in nursing administration as experienced by staff nurse subordinates of nurse administrators of cancer services.

Review of the literature, including examination of multiple data bases and conventional library searches, disclosed distinct groupings according to the following categories: (a) caring and clinical nursing practice, (b) transformational leadership, (c) leadership within nursing, and (d) caring in non-clinical nursing practice contexts. Although there appeared to be many similarities in the characteristics of both transformational leaders and
nurses engaged in caring relationships, none of the literature reflected an effort to combine the two concepts. Nursing leadership had been examined from the perspective of transformational leadership, but there was no link to the caring practice base of administrators who were nurses. The concepts of caring and its actualization in nursing administration practice were explored, but never related to leadership theory. Thus a gap in the literature related to the pairing of transformational leadership and caring in nursing administration was identified. Given the similarities between the two, caring as evidenced by nurses engaged in clinical practice and transformational leadership as evidenced by nurse administrators, this dissertation was conducted to bridge the gap and create an understanding of the common elements and effects of caring leadership in nursing administration.

The complexity of exploring the practice and effects of caring in the leadership of nurse administrators resulted in the selection of multiple methodologic approaches. Coordination of these approaches was achieved through the application of triangulation, the predetermined, systematic combination of complementary research techniques. A purposive sample of six nurse administrators of cancer services, and their staff subordinates, were selected for this study. The administrator participants were interviewed
and asked to reflect upon and describe their practice as nurse leaders and administrators. A survey instrument which measures nurse manager caring behaviors was completed by each administrator participant and respective staff subordinates.

The interview narratives were analyzed using manifest and latent content analytic techniques. The analysis resulted in the emergence of three themes: (a) a person centered value system rooted in the reality of clinical practice, (b) courage and sensitivity in decision making, and (c) the intentional cascading effect of caring leadership. These themes were present in all the narrative interviews. Analysis of the surveys provided complementary data regarding the themes: through cascading caring leadership and humanistic-altruistic values staff felt cared for and about by managers; the effects of administrative decision making related to financial constraints could be reflected in staff perceptions of manager caring. The application of multiple research approaches contributed a wholeness to the understanding of caring in the leadership practice on nurse administrators.

Discussion

This chapter examines the challenges and opportunities suggested by the findings of this study. Conclusions are drawn about the experience of caring in the leadership
practice of nurse administrators as realized from the process and experience of analyzing the words of study participants. Limitations, recommendations for further research and implications of this study for current theory and professional practice are presented.

Implications

Nursing administration was examined in this study within the frameworks of both caring and transformational leadership theory. Three themes emerged from interview data which revealed the intertwined nature of these theoretical frameworks in the practice of nurse administrators. A person centered value system rooted in the reality of clinical practice was the first theme. Nurse administrators have a high regard for the individual person within the organization system. A humanistic-altruistic value system, which has origins in clinical practice, permits the administrator to convey empathy, kindness, and candor in relationships with subordinates. The conviction with which participants spoke of this theme renounces the anonymity and harshness which may be experienced in healthcare organizations. As financial constraints are realized more frequently in terms of human costs, layoffs and cutbacks, healthcare organizations may be tempted to retreat to a depersonalized perspective which focuses on the whole of the organization at the expense of the individual. Maintaining
a person centered value system will be an increasingly necessary challenge for nurse administrators. Given that the focus of health care is on the human person, it is imperative that care be delivered in an environment which values and nurtures the individual.

A humanistic value system when combined with a patient/client focus equips nurse administrators with the necessary foundation for guiding organizations in the provision of such an environment. Specific examples of leadership behaviors and actions which promote staff subordinates feeling valued as individual members of an organizational enterprise were revealed in this study. These include creating opportunities for subordinates to take risks and succeed; acknowledging the importance of the work done by subordinates; and delegating authority to subordinates, empowering them and using their full capacities for the benefit of the organization.

In addition, the administrator who is also a nurse brings a unique perspective to the organization; one that is based in the clinical knowledge gained from nursing practice. Continued retention of this clinical component - knowing the clinical - permits the nurse administrator to maintain a comprehensive perspective of the healthcare system. Nurse administrators must value this clinical knowledge highly enough to make it a reality. This means
consciously scheduling time in which the administrator meaningfully interacts with staff and on occasion, patients and families. With increasing pressures arising from and attention given to the economic/fiscal components of the nurse administrator's role, it will be more difficult and yet imperative that the clinical knowledge is retained.

Finally, nurse administrators bring a unique focus on the patient - the recipient of care. The nurse administrator must promote this patient focus at every opportunity as it serves as a foundation for decision making, consensus and coalition building, and ordering priorities. Healthcare organizations will experience ongoing processes of evolution with no template for success. The continued focus on patients and patient outcomes provides as clear a map as is going to be found. Through humanistic, person centered value systems which originate in the reality of clinical practice, nurse administrators can make important contributions to successful organizational transitions through changing and challenging environments.

The second theme, courage and sensitivity in decision making, presents the challenge to nurse administrators of not only making difficult decisions when necessary, but also assisting subordinates and colleagues in seeing both the decision and their place within the larger context of the organization. The humanistic perspective described in theme
one assists the nurse administrator in maintaining concern for the individual while evaluating the effect of decisions. Sensitivity is evidenced by nurse administrators when they are able to detect the milieu within the organization and reflect this back in a deliberate effort to promote insight and action. The focus of these efforts may be the individual or the organizational unit. As healthcare organizations undergo rapid change arising from external and internal decisions, the nurse administrator brings unique skills to assist in evaluating the impacts of these decisions. The result is a facilitated change process. Nurse administrators possess important abilities to appreciate and master the complexities of the organization. Through management of the social, political, and technical aspects of the organization, nurse administrators gain a complete picture which allows for informed and creative decision making. Ambiguity and uncertainty are hallmarks of revolution and permeate the healthcare industry. The nurse administrator who clearly espouses a position based on values, even in the face of opposition, can provide individuals and groups within organizations with faith and hope in something beyond themselves. This faith and hope becomes the anchor to which vulnerable people are secured and gain stability. The need for stability and security in the ever-changing healthcare organization cannot be
overstated. Successful transition through these changes is inversely related to the degree to which staff feel alienated from the work of the organization. Nurse administrators support individuals through changes, providing a steady stream of resources and compassion, resulting in subordinate trust that needs will be met. The subordinates' sense of belonging to a larger effort then results in alignment and connection to the organization's values. The outcome is order out of possible chaos.

The intentional cascading effect of caring leadership, the third theme, is an acknowledgement of the inability of nurse administrators to personally provide caring for each individual patient. Nurse administrators provide caring environments for subordinates with the intended outcome of influencing the patient experience of caring. The leadership effectiveness of nurse administrators can be measured by their ability to make their vision of a caring culture meaningful to subordinates. The nurse administrator has the opportunity to enter into caring relationships with subordinates, learning of their needs, wants, and aspirations, creating a shared vision of caring. Following the creation of this shared vision, the nurse administrator must provide environmental supports within which the vision becomes a reality. These supports may take tangible, even mundane forms such as ready access to necessary supplies.
Or such supports may be more obscure, such as supporting subordinates in risk taking: challenging without overwhelming them and seeking opportunities for them to be successful.

The evidence of a cascading effect of caring leadership reveals that staff will experience and exhibit similar leadership qualities as the nurse administrator, but to a lesser extent. In addition, the organizational context greatly influences subordinate perceptions of manager caring. These processes of attenuation of the administrator's caring behaviors put an immense responsibility on nurse leaders. The more harsh the surrounding organizational environment, the greater are the required caring efforts of the nurse administrator. As described by Kahn (1993) this challenge to administrators lies in the creation of supportive networks which attend to and nurture the caregivers so that they may give care to others. This attention and nurturing must also be applied to the nurse administrators themselves as they develop their own networks of caring support.

The findings of this study as described in the three themes have implications for both transformational leadership and caring theories. The strong presence of caring and transformational leadership factors found throughout the participant interviews indicates the
importance of these theories in the work of nurse administrators. The administrator participants were able to shed light on those behaviors, efforts and actions which are consistent with both transformational leadership and caring. Moreover, the participants gave specific approaches that can be taken when a leader actualizes transformational and caring leadership. The identification of these specific approaches is of significant assistance in quantifying the ambiguous transformational leadership factors. These approaches also clarify the ways in which the nurse administrator applies caring within leadership. The behaviors and approaches described in this study can be analyzed, reproduced and taught to developing leaders. For these reasons, the findings of this study extend the previous body of knowledge in caring and in transformational leadership.

Nurse administrators are challenged to create a caring ideology: a set of major values and ways of perceiving and thinking about the world. Ideology is both what one believes and how one came to hold these beliefs. Burns (1978) proposed the use of ideology as a diagnostic instrument; a model in which there is congruence in the key elements pertaining to cognition, conflict, consciousness, value and purpose (p. 250). For nurse administrators, achieving a caring ideology requires the leader and follower
to perceive caring in one another; the potential conflict between economics and human care draws them together; they acknowledge the social and historical caring consciousness of nursing practice; humanistic/altruistic values hold moral significance for them; and they share a sense of social and political purposes which emerge from the caring ideology. As Burns has asserted, such "an ideological movement united behind moral purpose and united by conflict with opposing ideologies is a powerful causal force;...It is transforming leadership" (1978, p. 251).

Heroic leaders were identified by Burns as those who arise in organizations undergoing profound crisis and are linked to ideological leadership. The current healthcare environment provides ample opportunities for heroic nursing leadership. Nurse administrators become heroic leaders when subordinates believe in them based on their character alone and have faith in the leaders' power to overcome obstacles and crises; leaders and subordinates develop a type of relationship which is absent of conflict. These new nurse leaders are not idolized; instead, they are authentic leaders engaged in true relationships with followers, relationships characterized by: shared goals of caring; deeply held humanistic/altruistic values; and lasting influence as evidenced by actual organizational change which is sensitive to the impact of change on the individual.
By promoting and retaining a caring ideology, nurse administrators can provide the heroic leadership necessary to transform healthcare. The narratives of each of the participants in this study are a tribute to the ability of nurse administrators to rise to this challenge.

Limitations

This inquiry into the leadership of nurse administrators has revealed previously unidentified linkages between transformational leadership and human caring theories. As the participants spoke freely of their work as nurse administrators, it became apparent that there was no commonly accepted vernacular or taxonomy for them to use in describing their particular leadership experiences. This void may have restricted the participants from fully exploring their experiences and is therefore considered a limitation of this study. The emergence of three themes of caring, transformative leadership in nursing administration provides a beginning framework for the development of such a language.

The complexity of this investigation posed challenges to this novice investigator. Approaching the process of inquiry from multiple data sources and theoretical frameworks is a considerable undertaking. Although the methodology was carefully thought out and executed, this should be considered another limitation of the study.
Recommendations for Further Research and Education

The leadership of nurse administrators in this study was revealed as having aspects which are both transformative and caring in nature. Staff subordinates reflected the perception of being cared for by managers to a lesser degree than nurse administrators perceived themselves to care for subordinate managers. What is the nature of the interactions between the administrator, the manager and the staff which results in these varied perceptions? Simultaneous exploration of all three levels of experience would provide important clues to the structures and actions which support a caring ideology.

The cascading effect of caring leadership was explored in this study as a method of leaders modeling desired behaviors for subordinates. Additional inquiry into the processes of selecting subordinate managers may reveal how administrators view these managers as instrumental in achieving caring and transformative leadership.

There were differences in staff perceptions of manager caring among the data sites. Some of these differences have been attributed to the context of each organization, particularly related to change that was traumatic in human terms. Specific investigation of correlations between such changes and staff perceptions of manager caring could provide nurse administrators with important clues to
promoting stability.

Finally, to complete the circle of a caring culture, it will be necessary to examine the effects of nurse administrator leadership on organizational outcomes. Perhaps the most significant outcomes to be monitored are those which are clinical in focus. The provision of healthcare which results in optimally effective clinical outcomes for patients is the bottom line for nurse administrators and the organizations in which they work. Conducting such investigations will be challenging, but are an essential next step. The results may allow nurse administrators to identify those factors influencing patient care outcomes which are and are not under their control and how to gain the maximum desired effect in either situation.

The graduate educational preparation of nurse administrators has historically included course work in administration. The content of administration courses, while addressing leadership theories, is often lacking in the actual development of nurses as leaders. The findings of this study have implications for the leadership development of nurses. Specifically, there are common themes found in the practice of nurse administrators who are organizational leaders. These themes can be analyzed according to the code categories and behaviors which were found in the practice of the administrator participants.
Developing leaders, after becoming aware of such specific strategies and behaviors, can intentionally incorporate them into their leadership practice. For example, the participants of this study spoke of the significance of promoting subordinate identification with the larger organizational efforts during times of transition. Specific strategies devoted to this identification related to developing faith and hope and helping-trusting relationships with subordinates through shared goal setting, setting out a clear vision, and reinforcing the contributions made by each subordinate. The potential contribution of the findings of this study to the education of current and future nurse leaders is significant.

Conclusion

This inquiry began as an extension of the leadership experiences of the investigator. These experiences included the juxtaposed requirements to preserve and promote the caring ideology of nursing while simultaneously providing financial stewardship as resources became constrained. What type of nursing leader would be prepared to meet this challenge? Exposure to the parallel literatures of transformational leadership and human caring theory provided the motivation for this investigation.

The essence of the three themes of caring leadership is in the abstraction of relationships. Each of the themes
speaks to the significance of relationships for the nurse administrator: person centered values, sensitivity to self and others, and caring for others through relationships with others. As presented in Chapter II, Gilligan conceptualized the feminine perspective of relationships as a web or network, in contrast to the male perspective of hierarchy. The words of the study participants strengthen this concept of web and may hold clues to the transformations which will be required in healthcare administration during the next five years. Nurse administrators have the knowledge and imagery of relationships needed to make these transformations. As Gilligan summarized, "Since relationships, when cast in the image of hierarchy, appear inherently unstable and morally problematic, their transposition into the image of web changes an order of inequality into a structure of interconnection" (1982, p.62).

Nurse administrators are confronted with the duality of crisis and opportunity present in a healthcare environment in a constant state of transition. Maintenance of the caring heritage of nursing practice will prove to be the ultimate success of these nurse leaders. The role of great leaders, as described by Burns (1978) is all the more powerful and authentic if they make leaders of their followers. Nurse administrators possess the knowledge,
skills, abilities and spirit to meet the challenges of maintaining a caring ideology by making leaders of their subordinates. This charge to become "keepers of the caring clan" is summarized in the words of Lynn, one of the administrator participants:

I think it will be interesting, in the years to come, to see where caring fits and falls out in healthcare in general and certainly in the nursing profession. I would hope that we don't lose sight of caring with all the changes that are going on and the demands that are being placed on the healthcare system, from government, from society. I think it will take a special group of nursing leaders to make sure that doesn't happen. I think we have that group in this country and I hope that they can stay refueled and continue to foster caring.

The perceptions, common elements and themes, and subordinate effects revealed through this study, portray nurse administrators as leaders ready to meet the challenge of caring; a challenge that is not without risk but also not without rewards. This challenge of caring has been conceptualized by Watson as taking the form of nursing standing on a precipice, waiting to create new realities.

Nursing on the caring edge is actually a pioneer trying to find a new path through the maze of tradition, convention, and dogmas. Nursing and women are creating a new consciousness of their place in the system and in
the universe, and a new awareness of the interrelatedness of all life. Nursing in this sense is on an evolutionary edge of human consciousness (1987 p. 15).
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APPENDIX A

THE EXPERIENCE OF CARING IN THE PRACTICE OF NURSING ADMINISTRATION

INFORMED CONSENT STATEMENT

The purpose of this interview is to explore the concept of caring as it is experienced in the leadership practice of nurse administrators. The findings of this interview will contribute to a fuller understanding of the unique leadership styles of nurse administrators, and the possible contribution of caring to their administration practice. There are no foreseeable risks to participants associated with this study and your participation is voluntary. You may withdraw from this study at any point without reprisal.

Unstructured interviews will be conducted by Barbara L. Summers, a doctoral candidate at George Mason University, College of Nursing and Health Science. The interviews will be taped and will take about one hour. You will be asked about your current practice as a nurse administrator, and your past experiences in patient care situations.

Your responses will be compared qualitatively to those of other nurse administrators to establish aspects of caring in leadership. These findings will then be compared with responses given by staff nurse participants working under your supervision, relating to their perception of manager caring behaviors.

Your responses will be edited so far as it is possible, so that you, your position, and your institution are not recognizable. Because of the nature of this study, however, it is not possible to assure complete anonymity. You will have the opportunity to review your responses and to clarify any data that you may perceive to be inaccurate. Any area marked by disagreement between you and the investigator will result in negotiation until both parties are comfortable with the results. If for some reason agreement cannot be reached, that section of the interview will be excluded and so noted. In addition, if your interview or a portion of it is used as an exemplar, additional caution will be exercised to come to agreement with you about the presentation of the information.

In addition, you will be asked to complete a survey which measures staff nurse perception of manager caring behaviors. This is the same survey which will be completed by the staff in your institution. Your scores on the survey will be compared to those of your subordinate staff.
The Experience of Caring in the Practice of Nursing Administration

Informed Consent Statement

All data will be held in confidence. The transcriptionist will be advised of the confidential nature of the tapes and transcripts. All tapes and transcripts, when not being transcribed, will remain in the possession of the investigator. Identification of participants and their institution will be deleted from the transcripts.

If you have any concerns about the study, please contact Barbara Summers at [redacted] or my dissertation director, Rita Milberger, at [redacted]. You may also contact the chairperson of the Institutional Review Board (IRB) if you have any questions or comments regarding research subjects' rights.

You may request a copy of the final report of the research. The findings will be used to help those involved in nursing administration.

AUTHORIZATION:

Based upon my comprehension of the above informed consent statement, I am willing to participate in the interviews conducted by Barbara L. Summers in connection with her doctoral dissertation. Further, I give my permission for information I provide in the interview to be used for publication in research articles, books, and/or teaching materials, as well as for presentation at research symposia and/or education workshops and seminars.

__________________________  ____________________________
Date                           Signature

__________________________  ____________________________
Date                           Witness
Appendix B

THE EXPERIENCE OF CARING IN THE PRACTICE OF NURSING ADMINISTRATION

INFORMED CONSENT STATEMENT

This study is being conducted to examine the concept of caring as it is experienced by staff nurses and nurse administrators.

If you agree to participate, you will be asked to complete a survey instrument in which you rate the activities that occur among people on a nursing unit.

Your participation is voluntary, and you may withdraw from the study at any time and for any reason. There is no penalty for not participating or for withdrawing. The personal benefits for participation are the ability to contribute to an exploration of a central component of nursing practice. There are no costs to you or to any other party.

All data collected in this study will be coded by a unique 5-character string of numbers and letters and will not be identified with you personally.

This study is being conducted by Barbara L. Summers, a doctoral student in the College of Nursing and Health Science at George Mason University. She may be reached at 7 for questions or complaints. You may also contact the George Mason University Office for Research at 7 if you have any questions or comments regarding research subjects' rights.

This project has been reviewed according to George Mason University procedures governing human subjects research.

Completion of the survey is indicative of your voluntary agreement to participate in this project.
During this interview, I would like you to tell me about your administration practice, and how caring may be a component of that practice. In particular, I want you to talk about how you view yourself as a leader, how your interactions with subordinates are influenced by your leadership, and the effects of your leadership on the practice of nursing in your organization. As you are thinking about telling me these views, try to recollect specific moments which are memorable to you as a reflection of your administration practice. These moments may be memorable because they signified an important point in your career, pleasant or unpleasant, or the moments may be a reflection of your daily practice.

Throughout the interview, I will engage in the conversation in attempts to clarify points, to expand upon comments, and generally to facilitate your giving a complete description of your experiences. I will use comments and phrases such as "Can you give me an example?", "What was it like?", "Tell me more about...", "Can you give me more details about that experience?"

I would like you to review and think about the following statements in preparation for the upcoming interview. You may make a few notes to remind yourself of an important point, but do not spend time writing responses to the statements. I am primarily interested in your verbal description of what it is like to be caring as an administrator.
How did you decide to become a nurse?

Tell me about your interactions with patients when your role was that of a clinician. How did you use/view caring as a component of that clinical practice?

Tell me about how you came to be in an administration role.

Describe the transition for you from clinician to administrator.

Now, focusing on your experiences as an administrator, describe yourself as a leader.

How would others describe you as a leader?

Tell me about your interactions with subordinates. How do you view/use caring as a component of your administration practice?

What is it like to be caring as a nurse administrator?

What do you believe to be the effect(s) of caring in your leadership practice?

Think about your leadership style/behaviors and then compare and contrast them to those of other nurse administrators.

Think about your leadership style/behaviors and then compare and contrast them to those of non-nurse administrator colleagues.

Describe how you would picture/envision yourself in the ideal world as a nurse administrator. How does this compare to reality? Is the ideal possible? If so how? If not, why?

See Next page for continuation....
The Experience of Caring in the Practice of Nursing Administration

SEMI-STRUCTURED INTERVIEW GUIDE
Page three

Do you think your selection of oncology as a focus influences your leadership/caring? If so how? If not, why?

Can you describe any changes in your leadership style over time? What do you think contributed to these changes?

Think about personal experiences you have had in which caring was clearly evident in the leadership of a nurse administrator—yourself or another. Describe this experience. Next, think about an exemplar of non-caring in the leadership of a nurse administrator. Describe this experience.
Appendix D

Caring Assessment Tool - Administration Version
STAFF NURSE SURVEY
CAT-ADM.

Directions: All of the statements in this questionnaire refer to activities that occur among people on a nursing unit. There are five possible responses to each item. They are:

1 = Never
2 = Rarely
3 = Occasionally
4 = Frequently
5 = Always

For each statement, please circle how often you think each activity is occurring in your situation.

Since I have been a nurse here, my head nurse/nurse manager:

1. Listens to me.
   1 2 3 4 5

2. Accepts me as I am.
   1 2 3 4 5

3. Treats me kindly.
   1 2 3 4 5

4. Ignores me.
   1 2 3 4 5

5. Answers my questions.
   1 2 3 4 5

6. Includes me in her/his discussions.
   1 2 3 4 5

7. Respects me.
   1 2 3 4 5

8. Is more interested in her/his own problems.
   1 2 3 4 5

9. Pays attention to me.
   1 2 3 4 5

10. Enjoys working with me.
    1 2 3 4 5

11. Uses my name when talking to me.
    1 2 3 4 5
Since I have been a nurse here, my nurse manager/head nurse:

12. Is available to me.
   1 2 3 4 5

13. Seems interested in me.
   1 2 3 4 5

14. Has no time for me.
   1 2 3 4 5

15. Helps me to believe in myself.
   1 2 3 4 5

16. Keeps me informed.
   1 2 3 4 5

17. Fails to keep her/his promises to me.
   1 2 3 4 5

18. Encourages me to think for myself.
   1 2 3 4 5

19. Supports me with my beliefs.
   1 2 3 4 5

20. Encourages me to ask questions.
    1 2 3 4 5

21. Helps me to see the positive aspects of my situation.
    1 2 3 4 5

22. Encourages me to continue working here.
    1 2 3 4 5

23. Anticipates my needs.
    1 2 3 4 5

24. Encourages me to talk about my concerns.
    1 2 3 4 5
Since I have been a nurse here, my nurse manager/head nurse:

25. Openly shows concern for me.
   1  2  3  4  5

26. Asks me about my family.
   1  2  3  4  5

27. Shows any emotion.
   1  2  3  4  5

28. Asks how I would do things.
   1  2  3  4  5

29. Helps me deal with any negative feelings.
   1  2  3  4  5

30. Shares personal information with me when appropriate.
    1  2  3  4  5

31. Expresses human emotions with me when appropriate.
    1  2  3  4  5

32. Responds honestly to my questions.
    1  2  3  4  5

33. Initiates conversations with me.
    1  2  3  4  5

34. Checks on me frequently.
    1  2  3  4  5

35. Looks me in the eye when she/he talks to me.
    1  2  3  4  5

36. Refuses to tell me aspects of my work when I ask.
    1  2  3  4  5

37. Pays attention to me when I am talking.
    1  2  3  4  5

38. Acts as if she/he disapproves of me.
    1  2  3  4  5

Key: 1 = Never
     2 = Rarely
     3 = Occasionally
     4 = Frequently
     5 = Always
Key: 1 = Never
     2 = Rarely
     3 = Occasionally
     4 = Frequently
     5 = Always

Since I have been a nurse here, my nurse manager/head nurse:

39. Encourages me to talk about whatever is on my mind.
   1  2  3  4  5

40. Is patient with me even when I am difficult.
   1  2  3  4  5

41. Is interested in information I have to offer.
   1  2  3  4  5

42. Talks about me openly in front of other staff.
   1  2  3  4  5

43. Accepts what I say, even if it is negative.
   1  2  3  4  5

44. Seems annoyed if I speak my true feelings.
   1  2  3  4  5

45. Is aware of my feelings.
   1  2  3  4  5

46. Does not want to talk to me.
   1  2  3  4  5

47. Allows me to talk about my true feelings without any risk to my position.
   1  2  3  4  5

48. Asks questions about my past experiences in nursing.
   1  2  3  4  5

49. Helps me set career goals which I can accomplish.
   1  2  3  4  5

50. Helps me find solutions regarding my problems.
   1  2  3  4  5

51. Deals with my work problems in ways that are impractical to me.
   1  2  3  4  5
Since I have been a nurse here, my nurse manager/head nurse:

52. Helps me with all my work problems, not just part of them.
   1  2  3  4  5

53. Helps me deal with difficult situations
   1  2  3  4  5

54. Helps me understand my feelings.
   1  2  3  4  5

55. Asks me how I think my work is going.
   1  2  3  4  5

56. Helps me explore alternative ways of dealing with my work problem(s).
   1  2  3  4  5

57. Provides me with literature regarding my work and areas of interest.
   1  2  3  4  5

58. Uses management terms I don't understand.
   1  2  3  4  5

59. Knows what she/he is doing.
   1  2  3  4  5

60. Teaches me about nursing and health care.
   1  2  3  4  5

61. Discourages me from asking questions.
   1  2  3  4  5

62. Checks with me to make sure that I understand.
   1  2  3  4  5

63. Makes me feel as comfortable as possible.
   1  2  3  4  5

64. Tells me what to expect.
   1  2  3  4  5
Key: 1 = Never
    2 = Rarely
    3 = Occasionally
    4 = Frequently
    5 = Always

Since I have been a nurse here, my nurse manager/head nurse:

65. Knows when to go to a higher authority.
   1 2 3 4 5

66. Respects my need for confidentiality.
   1 2 3 4 5

67. Makes sure the charge nurse, assistant manager knows my strengths and weaknesses.
   1 2 3 4 5

68. Knows what to do in an emergency.
   1 2 3 4 5

69. Asks what I need.
   1 2 3 4 5

70. Protects me from situations where I could be harmed.
   1 2 3 4 5

71. Knows a lot about my work habits.
   1 2 3 4 5

72. Spends time with me.
   1 2 3 4 5

73. Makes me feel secure regarding my position.
   1 2 3 4 5

74. Allows my family to call the unit.
   1 2 3 4 5

75. Limits or interferes with my routine practices.
   1 2 3 4 5

76. Makes sure I get to meals or have time out for my own needs.
   1 2 3 4 5

77. Monitors my skill level.
   1 2 3 4 5
Since I have been a nurse here, my nurse manager/head nurse:

78. Keeps me challenged.  
1  2  3  4  5

79. Makes sure my paycheck is accurate.  
1  2  3  4  5

80. Makes me wait for a long time for an appointment when I need one.  
1  2  3  4  5

81. Helps me feel less worried.  
1  2  3  4  5

82. Allows me time off to be with my spouse and family/special friends.  
1  2  3  4  5

83. Discourages me from interacting with others.  
1  2  3  4  5

84. Helps me to achieve my career goals  
1  2  3  4  5

85. Respects my needs when scheduling my shifts.  
1  2  3  4  5

86. Doesn't care whether I get a break.  
1  2  3  4  5

87. Understands my unique situation.  
1  2  3  4  5

88. Has no idea how this job is affecting my life.  
1  2  3  4  5

89. Is concerned about how I view things.  
1  2  3  4  5

90. Knows what is important to me.  
1  2  3  4  5
Since I have been a nurse here, my nurse manager/head nurse:

91. Acknowledges my inner feelings.  
    1 2 3 4 5

92. Helps me cope with the stress of my work.  
    1 2 3 4 5

93. Shows respect for those things that have meaning for me.  
    1 2 3 4 5

94. Is out of touch with my daily world.  
    1 2 3 4 5

This is the end of the questionnaire.

If you were asked to advise nurse managers/head nurses and nurse administrators on what they need to do differently or better, what would you advise?

THANK YOU VERY MUCH FOR YOUR PARTICIPATION.
CURRICULUM VITAE

Barbara L. Young Summers was born on [redacted], in Aurora, Illinois, and is an American citizen. She received her Bachelor of Science and Master of Science degrees in Nursing from George Mason University in 1978 and 1981 respectively. Barbara has held many nursing leadership roles including clinical nurse specialist, clinical nurse educator, nurse manager, nurse administrator, and nurse researcher. She has worked in community hospitals, tertiary referral center hospitals and at the National Institutes of Health. In addition, Barbara has maintained active involvement in the formal university education of graduate nursing students, serving in a variety of faculty roles.

Barbara has held leadership roles within the Oncology Nursing Society, including chairperson of the national Administration Committee, Board Member of the Oncology Nursing Press, Inc. Board of Directors, member of the Leadership Task Force, and President of the local chapter.

Barbara has given many presentations, to international, national, regional and local nursing audiences. The topics of presentations are primarily related to nursing leadership. In addition, Barbara has several publications in professional nursing journals.

A member of Sigma Theta Tau National Honor Society of Nursing, Barbara has been the recipient of several awards and honors.