The nature of leadership style in nursing management

John Azaare, Janet Gross

Abstract
The purpose of this study was to explore the nature of leadership styles used by nurse managers, and describe staff nurses' perceptions of leadership styles. Effective leadership among nurse managers has been associated with staff nurse job satisfaction and retention. Twenty staff nurses from two hospitals in Ghana responded to tape-recorded interview questions. Four themes emerged from inductive analysis of the data. Findings suggest that nurse managers employed intimidation and minimal consultation to control their employees. The study further indicated that nurse managers were perceived as 'figure-heads', who are weak and inarticulate at the level of policy planning and implementation. It was therefore concluded that staff nurses in the study site hospitals lack confidence, trust and satisfaction with the current style of leadership. It is recommended that effective leadership training be instituted for prospective nurse managers before appointments are made into management and administrative positions.

Key words: Staff nurse ■ Nurse manager ■ Nurse-employee ■ Key informants ■ Lordship style ■ Non-consultative ■ Depowered leadership ■ Knee-jerk response

Nursing is a people-oriented profession with an emphasis on humanism, which probably influences leadership style (Sellgren et al, 2006). During times of dramatic organizational changes in health systems, nursing management is a challenging and difficult task. The style of the manager can be important for employees' acceptance of change and in motivating them to achieve a high quality of care (Bass and Aviolo, 1994). In Ghana, there is a gap in knowledge about how nursing leadership is organized even though a lot has been done in other parts of the world. There is an apparent inconsistency in the style of leadership provided by nurse managers. This could probably be attributed to the reasons for entering nursing leadership. In a study aimed at exploring why nurses enter nursing leadership and apply for a management position in health care, the first author noted that not much has been invested into the development of nursing leadership in Africa, particularly Ghana (Bondas, 2006). Findings revealed that nurses enter nursing leadership either by chance, career pursuit, or on a temporary basis (Bondas, 2006). With these themes in mind, one may want to enquire into the kind of leadership styles provided by nurse managers. The themes have been implicated in leadership problems, yet little evidence exists to support that notion.

The attitudes, values and behaviours of an institution begin with its leadership. This (leadership) is done through role modelling and communication at all levels (Kane-Urrabazo, 2006). Lindholm et al (2000) revealed that nurse managers who had a clear leadership style that was related mainly to a transformational or transactional leadership model experienced fewer management problems than nurse managers with a composite leadership style. There is a connection between nurse managers' attitudes towards the existing organizational culture and the leadership model adopted (Lindholm et al, 2000).

In Ghana, knowledge about the kind of leadership style employed by nurse managers is unclear. However, there is a perception that nurse managers' style of leadership is one of hostility and 'lordship'. This appears to create a sense of job dissatisfaction among professionals. In a study aimed at describing the types of cultures that exist and the management characteristics that are essential to facilitating a healthy workplace, Kane-Urrabazo (2006) stated that employee dissatisfaction is a major cause of staff turnover and can have financial implications on the agency. Nursing in Ghana has invested little in developing nursing leadership for the development of patient care (Bondas, 2006). Particularly, there is no researched information on the kind of leadership provided in the hospitals by nurse managers. The appropriateness of the style of leadership provided by nurse managers in Ghana also remains unclear, hence the need to explore existing styles of leadership. Findings could form the basis for establishing a well-structured system for training effective and efficient nurse managers.

Research questions
There were three questions which the authors sought to answer:
- What is the nature of the leadership style employed by nurse managers?
- How do staff nurses perceive the style of leadership being used by their nurse managers?

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Is the style of leadership used by nurse managers appropriate for quality and effective health care?

Research design
A qualitative, explorative and descriptive design was employed. Design was generally flexible, elastic and adjusted to new things as data were collected. A flexible approach was crucial to identify the relevant factors that should be studied in more detail in subsequent study (Hardon et al, 2001). Ethnography, the study of social interactions, behaviours, and perceptions that occur within groups, teams, organizations and communities was the qualitative methodology appropriate for this study (Reeves et al, 2008). Consistent with this approach, an in-depth interview was carried out with informants, aimed at providing rich, holistic insights into staff nurses' views on nurse managers' actions in the hospital setting.

Reeves et al (2008) noted that ethnography is effective methodology for addressing a range of research questions within the health professions. In particular it can generate rich and detailed accounts of clinicians’ professional and interpersonal relationships, their interaction with patients and their approaches to care delivery; precisely what this study sought to do. Data triangulation was carried out when field notes were taken in addition to tape-recorded interviews of 20 staff nurses in different settings at different points in time. Data analysis, which was an ongoing process, took an inductive thematic approach. Data were examined to identify and categorize themes and key issues that emerged from the data.

Research setting
This study was carried out in nursing units and wards of two hospitals. Letters were written to authorities at the hospitals to obtain permission to conduct the study. For ethical reasons the names of the hospitals where samples were collected for the study are withheld, and are referred to as H1 and H2.

H1
H1 is in the eastern region of Ghana with a total of 284 staff. At the time of the study there were 64 nurses and 71 ward aids and health extension workers, all under the umbrella of the nurse manager (director of nursing). Nine units came under the leadership of the nurse manager, including the eye unit, ear nose and throat unit, the outpatient department and the operating theatre, as well as with the maternity and antenatal care wards. Nurses operated a shift system enabling the hospital to provide a 24-hour service. The facility serves as a district hospital.

H2
H2 is in the central region of Ghana and has total of 418 staff, of which 193 are nurses, not including ward assistants. The nurses work in various units, including the orthopaedics and physiotherapy units, eye units, obstetrics and gynaecology, intensive care, public health, operating theatre, the outpatient department and six wards. As with H1, a shift system was used. The hospital is a referral centre receiving cases from various hospitals across the central region.

Population and sampling
Staff nurses from H1 and H2 who were on duty at the time of the research were interviewed. Two staff in each unit or ward were interviewed in 15- to 20-minute sessions. Quota sampling was used to obtain 20 staff nurses to participate in the study. This sampling method was used to ensure a research population with the same characteristics as the general nursing population. Criteria for sample selection were:
1. A staff nurse
2. Should have been practising in the selected hospital for at least one year
3. Should be at post;
4. Should be on duty at the time the research was conducted.

Ethical consideration
The study was approved by the first author’s supervisor from the Department of Nursing of the University of Cape Coast. Ethical principles, including the right to be informed of the study, the right to freely decide whether or not to participate, the right to withdraw, and the right to give informed consent (Orb et al, 2000), were applied.

Each participant received an information sheet in addition to a verbal explanation and was given the opportunity to ask questions about the study. Confidentiality was also assured, meaning that their identities were not revealed. Letters were also issued to the hospitals’ authorities to gain access.

Instrumentation
Information was gathered using tools divided in two sections: A and B. Demographic data formed section A, while section B was an open-ended semi-structured questionnaire. Pre-testing was done using key informants. This was to determine whether the instrument was useful in generating the desired information.

The questionnaires were reviewed by the first author’s supervisor and then restructured. The reviewed instruments were then used to conduct face-to-face in-depth interviews which were tape-recorded. Depending on an informant’s response, follow-up questions were asked. This was done to enhance flexibility and allow informants the opportunity to express themselves on the topic, in consideration of the exploratory and descriptive nature of the study (Hardon et al, 2001). Field notes were also made while interviews were conducted. This was done to enhance the validity of data gathered and also to capture significant statements that would be necessary for the analysis. Samples of the demographic data and the semi-structured interview questions can be obtained from the authors.

Data analysis
Analysis of data undertook an inductive thematic approach, in which meaning emerged from the data through exploration of all data sets. Data analysis was an ongoing process using inductive analysis and coding categories. Themes were developed taking into account data similarities for easy analysis. Comparative analysis investigating data similarities and dissimilarities was also considered. Observations, field notes and interviews were all included in the analysis.
Interviews were tape-recorded and transcribed verbatim. Collection and analysis of data was a sequential and simultaneous process and continued until data could add no new information to the emerging categories, and so-called saturation was met (Glaser and Strauss, 1967).

**In-depth interviews**

Individual interviews were conducted with nurses who met the selection criteria using convenient non-probability and quota sampling methods. Interview questions were semi-structured and had a high degree of flexibility. A flexible method of interviewing was used owing to limited knowledge on the topic and to allow participants the freedom to express their views concerning the kind of leadership they experienced. The questions were open-ended and started with 'whats' and 'hows'. Interviews were conducted on a one-to-one basis to encourage informants to speak their mind freely without fear of victimization. Interviews were recorded on a portable recorder and transcribed shortly afterwards, with the interviewer's impressions being added to the text. There were three interview phases: interviewing key informants, interviews in H1 and interviews in H2.

**Interviewing key informants**

Key informants were staff nurses believed to be working closely with the nurse-manager or officially assisting the nurse-manager. The research started by interviewing one key informant in each hospital. This was to test the effectiveness of the questionnaires and gather background information. The information gathered from the key informants was used for orientation towards the research topics. It was also used in redesigning the open-ended questionnaire.

**Interviews in H1**

Staff who met the selection criteria were recruited in different units and wards for the interview. Interviews took place on the morning shift on the first day and on the afternoon shift on the second day.

**Interviews in H2**

Staff who met the selection criteria were also recruited in different units and wards for the interview. Interviews were conducted during the afternoon shift on the first day and the morning shift on the second day. Information obtained was homogenous, prompting the researcher to carry out an interview session for staff on the night duty schedule. This was done three weeks later.

**Feedback**

Verification of the findings of this study by informants was done. Time and financial expenses did not allow a holistic collation of feedback from all informants; however, efforts were made to get the preliminary findings of the analysis and discussion of results to 12 informants (60%). An informant in H1 commented after reading this report:

‘Wow! I’m sure if matron [nurse manager] reads this she will say someone is plotting against her office.’

Another observed:

‘This piece reflects the way we [nurses] feel in this hospital... and I am sure the staff [nurses] will like to hear this. I urge you to come and share it with us.’

An informant in H2, after reading the results, observed that it was necessary to bring the content of this work to the notice of the learning institutions as it may impact on any recommendations that were made. He said:

‘I knew there will be revelations when you approached me in the night to interview me. Your recommendations should get to the university. I am sure it will help the course of nursing.’
Sixty percent of informants were females and 40% males. (Figure 1). There were no deliberate attempts by the researcher to select more females than males. Half of the nurses who responded to the interview questions were aged 20–29 years. Table 1 provides demographic data.

In terms of educational status, 70% of informants had only basic training from the nurse training colleges; 20% had undergone additional (specialty) training as well as their basic training and 10% had obtained a first degree from a recognized university.

Notably, only one informant had been in the profession for 10 years or more. The majority of the nurses (55%) had between one and five years’ service. As expected, most informants were in the category of staff nurses and were looking forward to obtaining promotion. However, 10% of informants rose to the rank of senior nursing officers, while 20% (n=4) obtained a first degree from a recognized public university in Ghana and are in the rank of nursing officers.

Table 2 shows the unit or ward distribution of informants from both hospitals in the study. The interviewer took the decision to draw participants from different units and wards to give a heterogeneous distribution of nurses’ opinions throughout each hospital. The disparity in the frequency of distribution in Table 2 was not deliberate and in the authors’ opinion has no significance to the study. It was due to instances where staff on duty at a particular unit were too busy to be interviewed, so that the researcher could only interview one member of staff in that unit.

Results
Leininger coined a phrase ‘ethnonursing research’ which she defined as ‘the study and analysis of the local or indigenous people’s viewpoints, beliefs, and practices about nursing care behaviour and process of designated cultures’ (1985: 38). This study analyses the viewpoints of staff nurses who work in the same environment as their nurse managers.

Leonard (1994) described the process of thematic analysis in hermeneutics. The analytical methods used in this study mirror her description. After completing the field work, the interviews and field notes were fragmented and processed. The processed data were then categorized into themes. Significant statements were coded and categorized for easy analysis. For example, a statement that sought to explain a positive influence by the nurse manager on the hospital’s internal management committee in terms of policy making and implementation was coded as P-IMC and a statement that suggested the nurse manager had little impact was coded as N-IMC where P and N means positive impact and no impact respectively.

Four themes emerged after analysing 126 significant statements: non-consultative leadership; abusive or hostile leadership; depowered leadership; and a “knee-jerk” type of leadership. Themes were developed from the repeated reading of data and then systematically applied during re-reading and discussion. In collating the information in these categories we attempted to answer the main research question: what is the nature of the leadership style in nursing management?

Table 3 presents a summary of significant statements that contributed to each theme that emerged.

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**Table 3. Characteristics of the four themes identified**

<table>
<thead>
<tr>
<th>Non-consultative leadership</th>
<th>Depowered leadership</th>
<th>Abusive/hostile leadership</th>
<th>Knee-jerk leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nobody knows what’s going on in this hospital</td>
<td>Not constructive when it comes to nursing issues</td>
<td>Nurse manager starts condemning you before listening to you</td>
<td>Nurse manager acts spontaneously</td>
</tr>
<tr>
<td>Nurse manager is autocratic</td>
<td>Nurse manager’s intimidated by college managers</td>
<td>Insults you in the presence of patients</td>
<td>Matron does not check facts before taking action</td>
</tr>
<tr>
<td>Nurse manager changes things to suit herself</td>
<td>The nurse manager is just a figure-head</td>
<td>May not query you but will insult you instantly</td>
<td>The matron may act and later feels sorry</td>
</tr>
<tr>
<td>We are only told any time changes should be made</td>
<td>The matron is unable to address allowances problem</td>
<td>Shouts at you anyhow, anywhere and at anytime</td>
<td>The nurse manager takes things personally</td>
</tr>
</tbody>
</table>

**Theme 1. Non-consultative leadership**
Informants’ responses to interview questions suggested that the matron’s office was open to every staff nurse who wanted to go there to express a concern or make an enquiry. Notably, there was a 100% ‘yes’ response to a question about whether a staff nurse could walk into the matron’s office at any time during working hours to voice any concerns. Informants, however, indicated that going to the office to present a concern was one thing—and whether the concern would receive the attention it deserved was another. One staff nurse commented: ‘The communication is good, but as to whether your needs will be responded to satisfactorily is another question.’ Some respondents, however, thought that though the office of the nurse manager was accessible, communication channels were flawed.

‘She can talk to you anywhere, anyhow and at anytime’.

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The nurse manager may bypass the ward nurse or nurse-in-charge to give official information to staff nurses. A nurse shared her experience:

‘There was a time the duty roster was prepared… to allow at least two staff nurses on duty including night shifts. The matron… went round the entire wards, removed all duty rosters and made changes to suit herself without consulting with anybody.’

Sentiments also appeared to play a role in the communication process. Some respondents were of the view that the nurse manager personalized issues about her office. This, according to them, prevents staff from coming forward should they have anything to say. So, do staff nurses have a say in decisions that affect their wellbeing? One staff nurse answered:

‘Clinical meetings are the only avenue for ward in-charges to meet and talk. Even at the clinical meetings, issues about patients’ care is central to all discussions and ward in-charges are another set of leadership.’

A total of 60% of informants (n=12) noted that staff nurses were not being consulted any time there was the need to make changes. An outspoken informant declared:

‘I would say that she is very autocratic, because we don’t know what is going on in this hospital. One of the nurses even left because he was frustrated. As for me I will say it…’

**Theme 2. Abusive/hostile style of leadership**

A leader’s approach to an issue or a wrong-doing by a member of staff will probably suggest their leadership style. The researchers wanted to explore the most likely reaction of the nurse manager who came across a staff member sleeping while on duty. Some nurses thought that the nurse manager would probably wake them up and find out if they were sick—which might be the only reason you are permitted to sleep at the work site. A staff nurse with about 10 years’ working experience was willing to share her experience.

‘Ha haa! Your question has occurred to me before. One time I was very tired after running night duty in the maternity unit for six nights... In the evening... I dozed off on the nurses’ table around 10pm... Matron was going on night rounds. She came to the ward and I was sleeping on the table. She took one of my shoes away... When I woke up a colleague I was working with told me the matron went away with my shoe while I was sleeping. I went to her office to collect my shoe. She asked me where I left it... and started talking plenty, plenty. I was so embarrassed.’

Depending on the severity of the offence, nurses could expect a verbal warning followed by a letter if the offence persists. This varies in different organizations, but verbal abuse by the leader to the offender is certainly not ethical. An informant admitted she would be unhappy to find a staff nurse sleeping while on duty and most likely would demand answers if she was a nurse manager. Differences in chosen leadership style will dictate differences in how situations are handled. She had this to say:

‘Any time you do something wrong like you missed your duty schedule, you will become the talk of the week. She will talk about you everywhere even when patients are around. Worst of all is if somebody has already angered her.’

Failing to honour your duty schedule can be serious but the above description did not appear to be one of the styles in current leadership theories. Insults have not been ruled out in the nurse managers’ most likely reactions. An informant noted that, ‘She will wake you up and insult you instantly. She might not even query you.’

**Theme 3. Depowered leadership**

Participants held the view that the nurse manager worked for the hospitals’ internal management committee (IMC) rather than represent the interests of the staff nurses. One staff nurse put it this way:

‘The matron is in the hospital’s management to represent us. If the internal management committee takes any decision that does not favour nurses, she will still support it because she thinks she’s part of the committee. She sees herself as part of committee… In this hospital nurses are the least represented.’

The above quotation is even more significant when the nurse manager is perceived to be giving answers to issues, which in the opinion of informants, should be taken to management for discussion. Informants described this as ‘defending management’. Eighty-five per cent of nurses (n=17) thought that the nurse manager’s presence on the wards would probably wake them up and find out if they were sick—which might be the only reason you are permitted to sleep at the work site. As for me I will say it...

‘As for the matron, any time you give a problem expecting her to carry it to management, she will start condemning you, showing that she cannot even take it there. Our allowances problems are not well addressed.’

One staff nurse did not hide his feelings about the
Theme 4. Knee-jerk kind of leadership

‘I will say that her influence is not there at all. Anytime there is an issue and you want her to help, she is not there to help us. We don’t see her working towards nurses’ goals. Left to me alone I would have wished we had a new matron.’

It’s worth noting that a participant preferred not to comment on the nurse manager’s competence claiming that the matron had her own style. She however admitted that there was a problem.

‘I would say that she has a knee-jerk response to issues.’

This was the response of a staff nurse who was asked to describe the nurse manager’s kind of leadership. Apparently, he was trying to say that the nurse manager immediately responds to issues before pausing to appraise them. Throughout the interview process, a significant number of informants conveyed an idea that the nursing leader had the tendency to allow one unpleasant encounter to influence the way she responded to subsequent problems. One was more likely to receive no for an answer if one needed a favour after the nurse manager had encountered a problem with a staff.

One other thing that took centre stage in this theme was the way a nurse manager treated a staff that was culpable. Indeed, instant rebuke and sometimes shouting may spontaneously precede any action by the nurse manager regardless of who was around or where the incident occurred. Eleven of the nurses (55%) expressed worry at how the leadership does fail to make thorough investigations into allegations, and may jump into concluding certain matters. Emotions have been noted to play a role in the leadership style of the nurse manager. The researcher gathered that it was not uncommon to see the nursing leader deal with staff angrily.

‘If she is in her good mood you may enjoy her.’

‘She allows emotions to dictate to her.’

‘If you are not lucky and somebody has already angered her, then trouble.’

The above quotations characterized the emergence of this theme. A total of 30% of informants (n=6) described the manner in which the nurse manager exhibited referred anger. Interestingly, one nurse remarked that it was the best way of dealing with different kinds of people.

‘For me, there is nothing wrong with that. You can become angry when you are dealing with all kinds of people as a leader and you don’t have to use one style.’ For her, anger seems to be a type of leadership style that could be approached in dealing with people.

When seeking the most likely reaction of the nurse manager if a staff was seen sleeping while on duty, this nurse responded: ‘It also depends on her mood’.

Credibility and trustworthiness

The credibility of this study was enhanced by the sample, which is representative of a typical hospital setting in Ghana. The sample was drawn from a variety of nursing units in two hospitals, each from different regions of Ghana using quota and convenient sampling methods (Polit and Beck, 2010). Saturation of data was also achieved after interviewing eight informants of H1 and six of H2. Nurses were eager to make known their reservation about the leadership style. The researcher then made a decision to interview 10 nurses from each hospital.

Discussion

The numbers reported in this study are exploratory but not conclusive; further research is needed. Sixty percent of informants were females. This supports Sellgren et al’s (2006) statement that nursing is a woman-dominated profession. Fifty percent of participants were aged 20–29 years old. This suggests the presence of young adults in nursing in Ghana.

The varying level of educational status reflects the levels of education among nursing professionals in the country. Level of education could influence the level at which staff nurses will appreciate the leadership style. Four types of leadership style were constructed from the findings through a method of inductive analysis (Johnson, 2004). These were non-consultative leadership, depowered leadership, abusive/hostile leadership, and knee-jerk kind of leadership. Staff nurses’ opinions, experiences and responses varied among the identified themes.

Noteworthy was the free nature by which staff nurses could walk to the office of the nurse manager to voice out their concerns. Nevertheless the ability to deal with such concerns as and when they arrived was almost nonexistent. One possible reason to this is the lack of power or authority by the nurse manager to promote the interest of nursing. The other could be the perceived subservience of nursing leaders to medical officers and financial personnel. Depowered leadership is evident here.

Informants also described that the nursing leader’s presence in the hospital’s IMC has been overshadowed by other members of the IMC. If passivity in the IMC was in the interest of staff nurses, it would not have been pointed out as a weakness of the nurse-manager. This suggests nurses preferred more proactive, articulate, and independent leadership who will ‘fight’ to promote the course of nursing. The above finding is also consistent with Sellgren et al’s (2006) work. Such form of leadership would be galvanizing the support of staff nurses for the course of nursing rather than being seen to team up with management to tame nurses. In such cases, informants concluded that the nurse-manager is just a figure-head.

There also appeared to be minimal trust in nursing leaders. This normally would be expected when leaders condemn, insult, and abuse employees. This might not
be healthy for an organization like a hospital, which wants to provide the best possible care to its clients. Gilbert and Tang (1998: 322) stated that: 'trust refers to employees’ faith in organizational leaders and the belief that ultimate organizational action will benefit employees. Depowered and abusive/hostile kinds of leadership characterized by inarticulate, transferred anger and insults may be responsible for distrust, and lack of confidence on nursing leaders. Kane-Urrabazo (2006) noted that while trustworthiness is a result of character and competence, trust is the actual act of believing in someone and having confidence in them. He added that the level of trust in an organization can foretell its success because it is a crucial element linked to employee performance and organizational commitment. One can therefore conclude that trust in nursing leadership is a necessary ingredient for staff nurses to give out their best.

Informants lamented over intimidation and dominating kinds of leadership by nurse managers and craved for a more pragmatic and stronger leadership at the top. This supports the findings of Morrison et al (1997), that nurses preferred their leaders to take a more active leadership role.

The ‘role culture’ category of organisational cultures, as described by Handy (1985), could be applied to the organizational structure of health care in Ghana. In the ‘role culture’ category there are distinct policies and procedures that control the organization, and employees operate based on job descriptions. Delivery of health care in Ghana is guided by policies and programmes developed by the Ministry of Health. Through the Ghana Health Services (GHS), policies and programmes are implemented. Functionally, the GHS is organized at five levels: national; regional; district; sub-district and community levels. Government hospitals at regional, district and community levels are under the auspices of the GHS at the respective level. Furthermore, job descriptions for all levels of nursing staff have been developed and are implemented at the national level regardless of the staff’s level of employment. Each job description defines one’s main duties and responsibilities as well as specific educational qualifications and experience necessary for advancement to each position. The bureaucratic nature of this organizational structure leads to feelings of powerlessness, particularly at the lower levels. This may explain why nurse managers employ intimidation to control employees.

The findings showed that there was seldom satisfaction experienced by staff nurses. Consistent with Kane-Urrabazo (2006), this may lead to employee turnover. Only 5% of informants had worked for 10 years and above. A majority of nurses (55%) had between 1–5 years’ service. The possibility of staying at post for a longer period of time is high. This conclusion might not be true in the event that there is employee dissatisfaction secondary to leadership style. In 1980 the nursing theorist Virginia Henderson commented on the historical background of repressive nursing administration, and provided recommendation that still holds true today: Nursing leadership is the key to maintaining the essence of nursing in an organizational culture where the nursing leader is not just a manager but also a leader of evidence-base care (Bondas, 2003).

Scoble and Russel (2003) asked nurse managers what competencies they thought were needed in the year 2020. The key competence was identified as leadership behaviour and specific items in the analysis were transformational leadership, visioning, and perseverance. On the contrary, the descriptions outlined by staff nurses in this study do not seem to portray nursing leaders as transformational in nature. Arguably there are many ways of transforming an employee for increased productivity, but insults and shouting will certainly not transform an employee positively. It will only decrease their morale, commitments and trust in the leader. From an overall perspective, there was an ambiguous leadership style which, in the opinion of the researcher, skewed more to transactional leadership rather than transformational. One possible explanation to this is the lack of career approach to leadership and the more emphasis on hierarchical authority (Lindholm et al, 2000).

Three key issues emerged from this study:
- Nurse-managers exhibit a domineering attitude towards their employees rather than envisioning the future and complementing the efforts of nurse-employees
- Staff nurses perceived that nurse managers lack the power to negotiate in favour of nursing at the management’s level
- Staff nurses perceived that the nurse manager works more for the interest of the hospital management than they do for the interest of nursing.

Limitations
The aim of research, independent of method used, is to produce findings that can be applied beyond the study setting. According to Malterud (2001), no study can provide findings that are universally transferable. Any such transferability to different cultures and/or health-care system should be done with caution.

Therefore, the results of this work can only be transferred to a hospital where: the nurse-manager’s role is not clearly defined; nursing leaders lack powers and authority in decision making; are subordinates to doctors and finance personnel; the choice of nursing leaders is not based on educational requirements and training but on seniority, promotion or long service.

Implication of findings to nursing
The large number of young nurses suggests nursing is likely to evolve. However, employee dissatisfaction and less motivation, as suggested in this study finding, may also discourage young nurses who may want to minimize psychological stress or salvage their future.

Nursing needs well-trained administrators who will
function independently and in the interest of nursing. The awareness created in this study may suggest that the traditional method of appointing nursing leaders based on seniority and promotion is not the best approach. Nursing students may need practical experience and/or attachment to make the theoretical learning of nursing management and administration more real and useful.

Finally, evidence-based care through nursing research may not receive the boost that it is needed if nursing leaders at the top are not proactive, articulate and independent. With only 10% of the nurses asked having a first degree, nurses need to create more room for further studies, especially in terms of broadening administration and leadership possibilities.

Recommendations

The study findings are suggestive rather than conclusive. Replication of the study is therefore recommended before conclusion. A further study is also recommended to describe the level of job satisfaction experienced by staff nurses and its relationship to the quality of health care. Effective leadership training should be instituted for prospective nurse managers before appointments are made to management and administrative positions. This means that higher learning institutions in the country, such as public and private universities, should develop curriculums and programmes to train professional nursing administrators.

It appears that the culture of using long service and promotion—where the next in rank to the ‘boss’ becomes the boss in the absence of the boss — as a tool to appointing nurses into leadership and management roles, may not be the way forward in the 21st century nursing. Factors such as trained leaders and administrators, interest and professionalism should be considered in appointing nurse managers instead of the traditional long service or seniority. Finally, nursing education in conflict management for staff nurses and nurse managers is needed.
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