THE UNIVERSITY OF
WARWICK

Library Declaration and Deposit Agreement

1.   STUDENT DETAILS

Please complete the following:

Full name: …………………………………………………………………………………….

University ID number: ……………………………………………………………………….

2.   THESIS DEPOSIT

2.1 I understand that under my registration at the University, I am required to deposit my thesis with the University in BOTH hard copy and in digital format. The digital version should normally be saved as a single pdf file.

2.2 The hard copy will be housed in the University Library. The digital version will be deposited in the University's Institutional Repository (WRAP). Unless otherwise indicated (see 2.3 below) this will be made openly accessible on the Internet and will be supplied to the British Library to be made available online via its Electronic Theses Online Service (EThOS) service.
[At present, theses submitted for a Master's degree by Research (MA, MSc, LLM, MS or MMedSci) are not being deposited in WRAP and not being made available via EthOS. This may change in future.]

2.3 In exceptional circumstances, the Chair of the Board of Graduate Studies may grant permission for an embargo to be placed on public access to the hard copy thesis for a limited period. It is also possible to apply separately for an embargo on the digital version. (Further information is available in the *Guide to Examinations for Higher Degrees by Research*.)

2.4 *If you are depositing a thesis for a Master's degree by Research, please complete section (a) below. For all other research degrees, please complete both sections (a) and (b) below:*

(a)   Hard Copy

I hereby deposit a hard copy of my thesis in the University Library to be made publicly available to readers (please delete as appropriate) EITHER immediately OR after an embargo period of ………..................... months/years as agreed by the Chair of the Board of Graduate Studies.

I agree that my thesis may be photocopied.   YES / NO (*Please delete as appropriate*)

(b)   Digital Copy

I hereby deposit a digital copy of my thesis to be held in WRAP and made available via EThOS.

Please choose one of the following options:

EITHER   My thesis can be made publicly available online.   YES / NO (*Please delete as appropriate*)

OR   My thesis can be made publicly available only after…..[date] (Please give date)
                                                                             YES / NO (*Please delete as appropriate*)

OR   My full thesis cannot be made publicly available online but I am submitting a   separately identified   additional, abridged version that can be made available online.
                                                                             YES / NO (*Please delete as appropriate*)

OR   My thesis cannot be made publicly available online.   YES / NO (*Please delete as appropriate*)

3. **GRANTING OF NON-EXCLUSIVE RIGHTS**

    Whether I deposit my Work personally or through an assistant or other agent, I agree to the following:

    Rights granted to the University of Warwick and the British Library and the user of the thesis through this agreement are non-exclusive. I retain all rights in the thesis in its present version or future versions. I agree that the institutional repository administrators and the British Library or their agents may, without changing content, digitise and migrate the thesis to any medium or format for the purpose of future preservation and accessibility.

4. **DECLARATIONS**

    (a) I DECLARE THAT:

    - I am the author and owner of the copyright in the thesis and/or I have the authority of the authors and owners of the copyright in the thesis to make this agreement. Reproduction of any part of this thesis for teaching or in academic or other forms of publication is subject to the normal limitations on the use of copyrighted materials and to the proper and full acknowledgement of its source.

    - The digital version of the thesis I am supplying is the same version as the final, hard-bound copy submitted in completion of my degree, once any minor corrections have been completed.

    - I have exercised reasonable care to ensure that the thesis is original, and does not to the best of my knowledge break any UK law or other Intellectual Property Right, or contain any confidential material.

    - I understand that, through the medium of the Internet, files will be available to automated agents, and may be searched and copied by, for example, text mining and plagiarism detection software.

    (b) IF I HAVE AGREED (in Section 2 above) TO MAKE MY THESIS PUBLICLY AVAILABLE DIGITALLY, I ALSO DECLARE THAT:

    - I grant the University of Warwick and the British Library a licence to make available on the Internet the thesis in digitised format through the Institutional Repository and through the British Library via the EThOS service.

    - If my thesis does include any substantial subsidiary material owned by third-party copyright holders, I have sought and obtained permission to include it in any version of my thesis available in digital format and that this permission encompasses the rights that I have granted to the University of Warwick and to the British Library.

5. **LEGAL INFRINGEMENTS**

    I understand that neither the University of Warwick nor the British Library have any obligation to take legal action on behalf of myself, or other rights holders, in the event of infringement of intellectual property rights, breach of contract or of any other right, in the thesis.

Please sign this agreement and return it to the Graduate School Office when you submit your thesis.

Student's signature: ....…… Date: ....

The Identity Work of Leadership in a Professionalised Context: The Case of Nursing

By

Charlotte Ogilvie

Thesis submitted in partial requirement for the degree of

Doctor of Philosophy

Warwick Business School

September 2012

Table of Contents

List of Tables and Figures

Acknowledgements

I would like to express my gratitude to my two supervisors: Professor Andy Lockett and Professor Graeme Currie. Their insights and support have been central to the evolution and completion of this thesis. I owe them great thanks for their unwavering encouragement and enthusiasm, and their continuing commitment to my professional development. It has been an honour to work with both of them.

I would also like to thank all the clinicians who gave up their time to take part in this study, for their candour and their insights into issues of professional leadership. At a time of great organisational change, resulting in pressured time constraints and concerns about job security, these study respondents always made time to talk to me. Without them this thesis would not have been possible.

Finally, I would like to acknowledge the important support of my friends and family, and to thank them for listening to me talk about leadership for three years. My parents, brother and sister have often offered interesting opinions around a dinner table, challenging me to think about things in different ways. In particular I would like to thank Dan for his stoic patience, optimism and sense of calm. Without him this would all have been a lot harder.

Declarations

I declare that the content of this thesis is all my own work and has not been submitted as part of any degree at another university.

Abstract

Existing research into leadership has relied on individualistic theories which do not provide a satisfactory understanding of the leadership process, particularly in organisations where focus has moved away from vertical, hierarchical leadership, towards more distributed or emergent models (Avery, 2004; Dess & Picken, 2000; Denis, Lamothe & Langley, 2001). It is assumed that individuals will emerge as leaders, and be viewed as effective, when they are regarded as prototypical, or representative, of the group they are attempting to lead (Hogg, 2001b; Hogg & Terry, 2000), and when they exhibit stereotypical leadership behaviours (Lord, Brown, Harvey, & Hall, 2001a; Offermann, Kennedy, & Wirtz, 1994). To date, research has assumed that the two identity concepts are compatible, with little consideration given to groups whose professional identity is dissonant with expected leadership stereotypes. The question therefore arises: how does professional identity influence ability of individuals to construct a leadership identity, when those identities are orthogonal?

To address this research gap I focus on leadership in nursing, a profession who have traditionally been defined by their subordination to doctors (Abbott, 1988; Allen, 1997; Campbell-Heider & Pollock, 1987). Combining real-time participant observation of two leadership development programmes with over 60 hours of longitudinal semi-structured interviews from 32 participants, I provide new insights into the chronic identity conflicts encountered by subordinate professionals, and the identity work they use to overcome those conflicts. Drawing on my analysis I develop a typology of four resulting identity constructions, with differing levels of leadership influence and identity conflict. In doing so I illuminate the processes through which subordinate professionals mediate de-coupled identities, challenging the assumption that the existence of a group identity is always beneficial and complementary to leadership behaviours (Hogg, 2001a), and highlight an arena where it can actually be detrimental to the emergence of a leadership identity.

1 Introduction

1.1 Theoretical Background

Effective leadership is commonly associated with organisational performance and often seen as key to successful organisational outcomes (Ford & Harding, 2007; Regine & Lewin, 2000). Dominant models of contemporary leadership, such as transformational leadership, focus primarily on the individual leader (Bass, 1990a; Bass, 1990b; Bryman, 1999), but a reliance on these theories has generated a body of leader-centric research. These studies have been insufficient in providing a satisfactory understanding of the leadership process, particularly in more complex organisations where leadership may not occur in a vertical, hierarchical fashion (Avery, 2004; Dess & Picken, 2000).

More recently, however, there has been an increased focus upon more distributed models of leadership as a means of improving organisational performance (Currie, Lockett, & Suhomlinova, 2009a; Day, Gronn, & Salas, 2004; Denis, Langley, & Cazale, 1996; Pearce, Conger, & Locke, 2007). The theory of distributed leadership suggests the need for a more emergent, informal and shared approach to leadership in complex organisations (Denis, 2007; Pearce, 2007; Marion, 2001; Mintzberg, 1998). Distributing leadership in this way could enable organisations to develop networks and increase innovation and organisational change (Day et al., 2004; Gronn, 2002). Whether or not the focus is on the individual leader, or a more distributed group, the challenge of adopting leadership roles and constructing leadership identities has been underplayed. Specifically, the ability of a potential leader to align their new leadership identity with their existing social identity, and particularly with their professional group membership, remains an under-researched issue (Carson, Tesluk, & Marrone, 2007; Currie, Finn, & Martin, 2010; Pearce & Conger, 2003). Issues of identity construction complicate the enactment of leadership, specifically the willingness of professionals, and the impact on their perceived legitimacy, when they move outside of their professional mainstream (Hogg, 2001c; Lord & Hall, 2005; McKenna, Keeney, & Bradley, 2004). Little research exists which considers the conflicts encountered by

individuals whose professional identity may prevent the stable construction of a leadership identity.

The Social Identity Approach (Haslam, 2004) offers an insight into the potential influence of identity on leadership development. The approach argues that individuals will emerge as leaders, and be viewed as effective, when they are regarded as prototypical, or representative, of the group they are attempting to lead (Hogg, 2001b; Hogg & Terry, 2000). The emergence of group leaders is therefore linked to their representativeness of collective ideals and values, emphasising the importance of prototypical and collective identities as antecedents of distributed leadership (Hogg, 2001b; Platow, 2001). In addition to conforming to their salient group identity, individuals in leadership positions are expected to exhibit stereotypical leadership behaviours, referred to in the literature as 'Implicit Leadership Theories' (Lord, Brown, Harvey, & Hall, 2001a; Offermann, Kennedy, & Wirtz, 1994); traits including sensitivity, intelligence, trustworthiness, being visionary, masculinity, and charisma (Den Hartog et al., 1999; Offermann et al., 1994). To date, research has assumed that the two identity concepts are compatible, with little consideration given to groups whose professional identity is dissonant with expected leadership stereotypes.

1.2 The Research Gap

Existing studies of leadership, therefore, do not adequately consider the influence of professional identity on leadership development and identity construction. Considering this research gap, I draw on the case of nurses, a group who have traditionally been defined by their subordination to doctors (Abbott, 1988; Allen, 1997; Campbell-Heider & Pollock, 1987). Nurses struggle to be seen as leaders within the National Health Service (NHS), both by themselves and others, as they continue to be socialised into a traditional nursing identity which is orthogonal to the modern day leadership roles they are expected to adopt (Chua & Clegg, 1989; Currie et al., 2010; Goodrick & Reay, 2010). Despite the paradoxes they face, subordinate professionals are ultimately capable of rising into successful leadership positions (Hart, 2004; Hughes, 1988; Wicks, 1998). I consider

the mediating influence of leadership development programmes, conceptualised as a space encouraging individuals to socially construct leadership identities (Carroll & Levy, 2010; Creed, Scully & Austin, 2002). How subordinate professionals overcome identity conflicts to construct stable identities within the context of leadership development programmes has not been addressed in previous research, which has primarily focused on traditional professions, such as medicine and law, whose identities are compatible with leadership (Iedema, Degeling, Braithwaite, & White, 2004; Kippist & Fitzgerald, 2009; Wallace, 1995; Waring & Currie, 2009).

The organisational context of nurses' leadership development plays an important part in this study. Recent policies and attempts at organisational reform advocate the importance of strong professional leadership, rather than management, for the future success of the NHS (Darzi, 2008; DOH, 2009). However, there is little or no consideration of the tensions inherent within the organisational structure and culture of the NHS, which may make leadership difficult for clinicians, and particularly nurses. This is demonstrated when examining the leadership development frameworks advocated for use within the NHS, which take a specific competency approach, and do not consider the identity conflicts which clinicians may encounter when adopting leadership roles (NHS Leadership Academy, 2011; Inst. For Innovation and Improvement, 2005). I acknowledge these issues and discuss the impact they may have on the construction of a successful leadership identity for nurses. This will also offer insights into organisational attempts to facilitate identity transition, alongside individual attempts at identity conflict resolution.

In this thesis I will offer an insight into how identity influences leadership, with a particular focus on the impact of professional identity. Considering this within the context of the nursing profession, I will explore the conflicts encountered by individuals whose salient identity is orthogonal with expected leadership behaviours. I consider how individuals attempt to resolve the conflicts they encounter when attempting to lead, and finally offer a typology of resulting identity constructions. In doing so I attempt to answer the research question: How does

professional identity influence the ability of individuals to construct leadership identities, when those identities may be incongruent?

To answer that question, two leadership development programmes within the same NHS Trust were selected as recruiting sites for participants. These programmes are not under scrutiny for their effectiveness or outcomes, rather they are seen as an arena which encourages identity transition construction (Carroll & Levy, 2010). They were selected as they offered access to a cross-section of nurses across different hierarchical levels and job roles, ensuring study participants were sampled from a stratification of the nursing hierarchy. I combined real-time participant observation of these leadership development programmes with longitudinal semi-structured interviews. A total of 32 interview subjects were recruited, from clinical, middle management, and executive level posts. The respondents were interviewed once at the close of the programme and followed up with a second interview one year later. 28 respondents took part in the second set of interviews, totalling over 60 hours of interview recordings. This data was then coded thematically to answer three aspects of the research question:

i) What are the conflicts encountered by individuals whose salient professional identity is at odds with expected leadership behaviours?

ii) How do these individuals attempt to resolve these identity conflicts?

iii) And finally, what are the resulting identity types constructed?

1.3 Contribution

I offer a two-fold contribution to theory: extending our understanding of the antecedents to distributed leadership; and illuminating the identity work employed by subordinate professionals undergoing identity conflict, in order to construct stable identities. The idea that a collective group identity is needed for the emergence of effective group leaders is reinforced, but the results also illuminate circumstances in which this can be both problematic and detrimental for potential subordinate leaders, due to the incongruence between their traditional and new identities and roles. Previous research into leader emergence has assumed the existence of a

group identity is always beneficial and complementary to leadership behaviours (Hogg, 2001a). In this study, I highlight an arena where the antecedents of distributed leadership, such as a strong collective identity, can be detrimental to the emergence and construction of a leadership identity.

The study findings discuss strong professional group identification, with most respondents engaging in behaviours associated with salient group identification, such as in-group favouritism and prototype aspiration (Ashforth & Humphrey, 1993; Ellemers et al., 2002; Hogg et al., 2003; van Knippenberg et al., 2004). As such, highly prototypical members were ideally placed to emerge as legitimate, formal leaders from within nursing teams, reflecting assumptions of the Social Identity Approach (Hogg, 2001a). I identify this process of professional leader emergence due to prototypicality, followed by a move into non-prototypical, managerial leadership, as the primary source of identity conflict, with lasting effects on the ability of individuals to construct a successful leadership identity. Whilst other professions are able to marry their traditional role with their managerial leadership (Llewellyn, 2001; Witman, Smid, Meurs, & Willems, 2011), I will argue that the opportunities for this within nursing are limited.

The conflicts encountered by respondents were compounded by the organisational context of the NHS, where nurse leaders are required to work within informal professional hierarchies, as well as management structures, in an arena where the subordination of nurses to doctors is the expected behaviour. Many respondents attempted to reduce their identity conflict by conforming to subordinate, passive behaviours, which encourages an occupational, vocational and subordinate ideology, perpetuates the existence of professional hierarchies within the NHS and maintains the assumption that nurses are not stereotypically appropriate leaders (Brooks, 1996; Currie et al, 2010; Hall, 2005; Jost & Elsbach, 2001; LaTendresse, 2000). I will consider how nurses often act in ways which perpetuate the existing informal hierarchies in the NHS, significantly undermining their own potential leadership abilities, but protecting their traditional sphere of professional influence.

6

An exploration into the impact of professional group identity on leadership emergence and influence also offers interesting contributions to theories concerned with Social Identity. Conceptualising identity as a socially constructed phenomenon (Goffman, 1959), I use the case of a highly salient professional group, whose core identity and sphere of professional influence is bound up with subordinance to a more powerful profession, to provide new insights into the identity work processes used by individuals in identity conflict. In attempts to resolve the identity conflicts encountered, I will show how individuals employed identity work, a process by which individuals actively construct their identities, and consequently set about communicating and portraying that identity to themselves and others (Watson, 2008, 2009). By socially constructing their identities in this way, actors legitimise their participation and role in group events (Creed et al, 2002). I identify three types of identity work in this study: aggrandising, demonising and splitting or fusing identities. Through an exploration of this work I will highlight the ways in which these processes perpetuate the status quo of professional hierarchies, protecting nurses' unique professional sphere of influence, and legitimising the core ideals of their professional identities. I will show how, paradoxically, the salience of their professional group membership is so strong, some will act in ways which undermine their organisational leadership influence.

I identify 'aggrandising' work as a self-enhancement mechanism, used to increase legitimacy and a sense of self worth. This can be used in two ways, depending on context and audience: aggrandising the importance of portraying and protecting traditional nursing identities; and aggrandising the need to adapt professional group identities in a non-prototypical manner, to achieve higher levels of organisational influence. 'Demonising' work can almost be seen as the opposite mechanism, undermining others to enable favourable in-group comparisons and further increase self-esteem and psychological group commitment (Crocker & Park, 2003; Dunning, 2003). Interestingly, I will show how this work was not used to undermine groups outside of the profession, but rather sub-groups within the profession, contributing to the process of on-going

professional stratification and the perpetuation of a culture which discourages leadership and ambition (Dingwall, Rafferty, & Webster, 1993; Freidson, 1988).

The final type of identity work involves the splitting or fusing of the two paradoxical identity elements: leader or clinician. By situationally 'splitting' their identities, individuals are able to compartmentalise different aspects of themselves, creating salience hierarchies. The results uncover numerous occurrences of this type of identity work. This enables conflicted individuals construct two separate identities, allowing them to evoke different behaviours and priorities in different situations, thereby projecting to others contingently different identities. On the other hand, 'fusing' identities enables individuals to retain multiple identities within a single persona, but not split them. These respondents construct a hybrid whole, a new type of identity which reflects elements of all their different group memberships (Pratt & Foreman, 2000). This 'layering' of identities has been noted as the way in which successful medical professionals move from a clinical to managerial role. New identities do not replace old ones but are layered on top of one another (Iedema et al., 2004). In this way individuals achieving a hybrid position should theoretically enjoy low levels of conflict as their previously paradoxical identities now lie harmoniously within a newly constructed identity.

The identity work generates of typology of four resulting identity constructions: clinician, manager, split hybrid and fused hybrid. Clinicians and Managers are constructed as relatively one-dimensional identity types, characterised by a rejection of one aspect of their conflicted identity to construct a singular, salient identity. Clinicians will remain in traditional nursing roles, only taking on informal leadership which does not challenge their professional identity. Similarly, managers reject their professional nursing identity, taking on formal positions of general management. Both clinicians and managers were unable to develop or construct an influential leadership identity, relying on their hierarchical job roles to define their sphere of influence.

The majority of study respondents hold job roles requiring them to fulfil at least some degree of managerial and clinical responsibility. To deal with paradoxical identity conflicts, many individuals split and compartmentalised the two aspects of their identities. I label this group 'split hybrids', individuals who adopt situationally salient identities in different contexts, actively associating with or distancing from conflicted aspects of their identities in different situations. I will argue that this identity construction is particularly associated with those in middle management positions. Split Hybrids appear to construct 'provisional selves' (Ibarra, 1999), identities which are constantly shifting between their new, conflicted role and their current capacity and self conception. In another sense, these individuals are caught in a liminal space, reducing their leadership influence and perpetuating large amounts of internal conflict (Beech, 2011). This group make up the largest number of respondents and make a clear statement about the ineffectiveness of nursing leadership.

The fourth identity construction, fused hybrids, fuse their managerial and professional identities to construct a whole new identity, affording both identity aspects the same level of importance. As such, professional and managerial identities are used equally to influence behaviour and guide actions. I suggest the fused hybrid identity construction is the optimal identity type for nursing leadership, echoing conclusions from research into medical hybrid leaders (Llewellyn, 2001;Diefenbach & Sillince, 2011; Iedema et al., 2004). However, I also acknowledge the organisational and professional difficulties associated with the construction of this identity, giving an insight into the struggles faced by all potential nursing leaders.

In addition to the theoretical contributions relating to professional identity and leadership, I also offer recommendations and implications for policy and practice. I use the study findings to highlight a need for a more identity-focussed approach to leadership development for professionals, and in particular those from subordinate backgrounds. I also suggest considerations for future healthcare policies relating to leadership, arising from the study findings. Further avenues of research are identified, in particular the need for further exploration of the process of identity transition from an unstable split hybrid to a fused hybrid identity.

1.4   Thesis Structure

The thesis is structured as follows. In the first chapter I offer a critique of popular theories of leadership, suggesting that a reliance on theories such as transformational leadership (Bass 1990a) has generated a body of leader-centric research. Advocating the need for leadership to be considered as a social process, rather than an individual action or singular event imposed on others (Day, Gronn, & Salas, 2006), I highlight the need for more research which acknowledges the embedded nature of leadership in the organisational and social context. This is particularly the case in modern, pluralistic organisations, where a reliance on traditional, individualistic models of leadership is no longer sufficient.

In the second chapter I conceptualise identity as a socially constructed phenomenon which is shaped through interaction with other individuals within social structures (Brown, 2006; Ibarra & Barbulescu, 2010; Lindgren & Wahlin, 2001; Wells, 2007; Schwalbe & Mason, 1996). I then consider the influence of professional identity through the lens of the Social Identity Approach (Haslam, 2004), and explore the potential impact on the successful development of a leadership identity. I draw on the case of nursing to illuminate an arena in which professional identities may be orthogonal with leadership identities, considering the identity conflicts which may arise during leadership development. This is followed up in chapter 3 with a consideration of the National Health Service (NHS), discussing its organisational evolution since its inception in 1948, focussing primarily on the dramatic changes it has undergone in the last 30 years. I will explore how the NHS has moved from a system of professionalism, to managerialism and finally towards an assumption that leadership is an organisational panacea (Currie, Boyett & Suhomlinova, 2005; O'Reilly & Reed, 2011).

Next, I outline the methodology which will be used to answer the research question: How does professional identity influence the ability of individuals to construct leadership identities, when those identities may be incongruent? As discussed above, the study results were collected

through a combination of participant observation and longitudinal semi-structured interviews with 32 respondents. I also outline the coding structure used to organise the data, which is then presented in three empirical chapters, each corresponding with one of the three sub-questions:

i)   What are the conflicts?

ii)   How are they resolved?

iii)   What are the resulting identity constructions?

Following on from the empirical chapters, I consider the findings in the context of existing knowledge and theory, in the discussion chapter. The final chapter, conclusions and implications, highlights the contribution I have made to existing theory and policy, and makes recommendations for future avenues for research. To conclude the thesis, I will offer a reflective account of my own identity transitions throughout the research process; mirroring the identity conflicts and attempts at resolution described by the study respondents. I chart my own identity transition, framed within the findings of the study, describing how I have moved from a professional identity of 'nurse', towards one of 'researcher'.

2   Leadership Theories

2.1   Introduction

Leadership is an increasingly important social phenomenon, seen as the key to effective adaptation and survival of successful global organisations (Ford & Harding, 2007; Regine & Lewin, 2000). The need to foster leadership skills amongst organisational members, to gain competitive advantage and increase organisational performance, is reflected in the proliferation of leadership development programmes across the private and public sectors in the United Kingdom (Day, 2000; Van Wart, 2003). However, leadership as a concept is enigmatic, with a multitude of dimensions and definitions (Barker, 1997; Burns, 1978). What it 'is' and how leadership success can be evaluated is fiercely debated.

Compounding this problem is a reliance on traditional, leader-centric theories, shaping much of the existing research in this field. These theories have been insufficient in providing a satisfactory understanding of the leadership process, particularly in more complex organisations where leadership may not occur in a vertical, hierarchical fashion (Avery, 2004; Dess & Picken, 2000). In this first literature review chapter, I offer a critique of these traditional theories of leadership and identify the need for more research into conceptualisations and theories acknowledging the embedded nature of leadership in the organisational and social context. I will advocate the need to consider leadership as a social process, rather than an individual action or singular event imposed on others (Day, Gronn, & Salas, 2006). Finally, I consider some of the problematic antecedents to leadership when conceptualised in this way, in particular the importance of identity.

2.2   Defining Leadership

The challenge of defining the leadership concept is a notably complicated one, ranging from a focus on individual 'heroic leaders', to a dynamic, contextual group process of 'leadership'

(Barker, 1997; Bass, 1990a; Burns, 1978; Yukl, 1989). Whilst research in the field has historically focused on the personal traits and attributes, or actions and behaviours of individual 'leaders' (Bass, 1985; Judge, Piccolo, & Kosalka, 2009), more recent attempts to conceptualise leadership have condemned the individualistic approach as flawed and oversimplified (Ahn, Adamson, & Dornbusch, 2004; Barker, 2001). The assumption that leadership resides within certain individuals, acting within formal hierarchical structures, is one which no longer reflects the complexity of modern organisational cultures, and neglects to consider the contextual influences on its enactment (Denis, Langley, & Rouleau, 2005; Kellerman, 2004; Uhl-Bien, Marion, & McKelvey, 2007).

Leadership cannot be appropriately defined in terms of the actions and characteristics of individuals. Instead, it is more effectively viewed as a discursive, contextual and dynamic process, which can be used as an abstract ideal with which to understand complex organisational phenomenon, rather than a fixed and observable event (Bryman, 1999; Kelly, 2008; Osborn, Hunt, & Jauch, 2002). It is this definition I will use to shape this thesis. Based on this assumption, definitions of leadership will alter according to temporal and contextual changes, with individuals constructing their own definitions and assumptions of leadership based on personal perceptions and experiences (Avery, 2004; Kort, 2008; Osborn et al., 2002). This allows exploration of organisational phenomenon in a fluid and contextual manner, rather than being constrained by a singular, functional definition of 'leadership' (Bresnen, 1995; Washbush, 2005).

A further obstacle in conceptualising leadership is the ability to assess the impact and outcomes of processes on organisations (Barker, 2001; Osborn et al., 2002; Svensson & Wood, 2005). Attempts at measuring leadership effectiveness have relied on traditional, individualistic assumptions, examining organisational outcome measures such as market shares and profits, and assuming there is a direct relationship between effective leadership and business outcomes (Svensson & Wood, 2005). Despite this assumption, there is little evidence to demonstrate a quantitative relationship between individual traits or behaviours and organisational performance (Howell, Bowen, Dorfman, Kerr, & Podsakoff, 1990; Kaplan & Norton, 2005). This

does not mean that leadership has no direct effect, but that the outcomes may be played out through social mechanisms rather than organisational output.

Qualitative attempts to determine the social impact of the leadership process have highlighted the social and contextual influences on perceptions of leadership effectiveness, and associated outcomes (Avolio, Reichard, Hannah, Walumbwa, & Chan, 2009; Giessner, van Knippenberg, & Sleebos, 2009). These subjective opinions highlight the vague nature of the concept, making it difficult for individuals to vocalise clearly and consistently how they view it (Alvesson & Sveningsson, 2003a, b). The rhetorical dimension of leadership further complicates the research, as its subjective nature means researcher perceptions and respondent bias will influence the standards and constraints of discourse (Alvesson & Sveningsson, 2003a, b; Connelly et al., 2000; Hooijberg & Choi, 2000; Yukl, 1989).

2.2.1   Managing or Leading?

Alongside the continuing challenge of defining what leadership 'is', runs the difficulty in discerning between 'management' and 'leadership'. Whilst some suggest there is no difference between the two concepts, and subsequently no need to define either (Kort, 2008), others note instances in which leadership is lacking, or in which it occurs outside of formal 'management' positions (Kotter, 1990). It is important to acknowledge the difference between the two terms, particularly when researching leadership emergence which can occur informally, without being in positions of hierarchical power.

In many cases the primary difference between the two concepts can be seen as essentially rhetorical, with leadership being used to denote positive actions and events, whilst management is seen in a rather more negative or mundane light (Alvesson & Sveningsson, 2003b). Positive leadership processes are portrayed as influencing people's thoughts and values, and motivating them to work together to break down organisational barriers and achieve change (Buckingham, 2005; Burns, 1978; Kotter, 2001; Kotter, 1990). In contrast, management processes are seen to

encourage conformity to organisational goals, maintaining stability and exerting formal authority by rewarding or punishing behaviour – the antithesis of leadership (Barker, 1997; McLean, 2005; Yukl, 1989; Zaleznik, 2004). This rhetorical element subsequently perpetuates the elevation of leadership to a higher moral plane, endowing mundane managerial acts with an almost mythical element and romanticising routine events (Alvesson & Sveningsson, 2003c). This romanticising of leadership means that anything associated with the concept will immediately take on more social worth and value than things associated with 'management', regardless of the work being undertaken (Meindl & Ehrlich, 1987). Therefore 'leadership' will be perceived as having a positive effect in all situations, reinforcing its perceived importance.

If the difference between management and leadership is only rhetorical, the two concepts can be used interchangeably. This is supported by an awareness that effective managers use a commination of managerial and leadership processes in their roles (Kent, 2005; Kent, Crotts, & Azziz, 2001; Kort, 2008; Kotter, 2001; Washbush, 2005). Leadership and management skills are seen as synergistic in order to encourage organisational development and innovation whilst maintaining the day-to-day functioning and stability of the organisation (Buckingham, 2005; Collins, 2001; McCartney & Campbell, 2006). Leadership is seen as an element required for managerial, and subsequently organisational effectiveness, due to its association with processes of change and adaptation (Avolio & Gardner, 2005; Day, 2000; Ford & Harding, 2007).

However, whilst Kelly (2008) argues that without management skills leaders are ineffective, the assumption that management and leadership roles are the same and the terms interchangeable, relies on the idea that individuals will only lead from formal management positions. This assumption is often challenged in research focusing on informal, emergent, or shared leadership (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Pearce & Conger, 2003). Whilst it is important to acknowledge the ways in which the terms can be used interchangeably, it is equally important to highlight that these terms are not mutually exclusive; it is possible to have leadership without management and vice versa. For the purpose of this study I acknowledge the

rhetorical interchange, but fundamentally rely on the premise that one can lead without being in a managerial position.

2.3   Theories of Leadership

There are a multitude of leadership theories, many of which are criticised as vague, contradictory and simplistic due to their reliance on an unsatisfactorily defined concept (Yukl, 2006). As a result, these theories are conceptually and empirically weak, potentially inhibiting the development of leadership research (Gronn, 2002; Yukl, 1989). Bryman (1999) determines three distinguishing categories of leadership theory: Individualistic approaches, contingent leadership, and new leadership theories. In this section I discuss the assumptions and problems associated with a reliance on these theories in existing leadership research, and propose the need to focus on a new category of leadership theories: leadership in context.

2.3.1   Individualistic Approaches and Contingent Leadership

Individualistic theories of leadership rely on the notion of 'heroic' individuals who impose actions on others, framing these individual actions and behaviours as 'leadership'. Trait theory relies on the assumption that people are born with innate personality traits, enabling them to become great leaders, whilst behavioural theories focus on how individuals can act to become effective leaders (Northouse, 2007; Yukl, 1989). These theories view the individual leader in isolation from social or organisational influences, and are often discredited due to a lack of empirical evidence demonstrating a clear relationship between individual leader traits or behaviours, and organisational outcomes (Hooijberg, Hunt, & Dodge, 1997; Howell et al., 1990; Yukl, 2006). When used in conjunction with other, more developed theories, the individualistic approaches can offer some insight into the characteristic and personal attributes of individuals who are perceived as effective (Bass, 1990a; Hooijberg et al., 1997; Judge et al., 2009). However, overall the theories are criticised for relying on simplistic notions of leadership as a static, individual event, without a consideration of contextual factors.

The contingency approach goes someway to addressing this gap, suggesting that different situations require adaptive leadership approaches and behaviours, in a dynamic, temporal fashion, rather than adhering to prescriptive models (Ahn et al., 2004; Northouse, 2007). The approach suggests that by matching leadership styles to contexts, leaders should be able to maximise their organisational effectiveness, due to their ability to adapt to the environment (Buckingham, 2005; Grint, 2005; Kent, 2005). Despite the advances on individualistic theories, contingency approaches remain flawed. The approach still relies on the idea of leadership residing within individuals, with no consideration of the leader on organisational context or their role within the wider system (Bass, 1990a; Grint, 2005). It offers no explanation of why some leaders will be more effective than others in different contexts, and again no clear empirical evidence of an impact on organisational performance (Howell et al., 1990; Thompson & Vecchio, 2009).

2.3.2 'New' Leadership Theories

The so-called 'New' theories attempt to resolve some of the flaws of the traditional approaches by identifying and developing the need for a contextual approach to leadership. Building on the idea of contingent leadership, they develop the importance of acting in relation to context, whilst also acknowledging the behaviours leaders need to influence followers. The theories are generally categorised into two styles: transactional and transformational (Burns, 1978).

Transactional leadership is often equated with managerial processes, relying on a system of rewards and punishments to ensure performance and achievement of goals (Bass, 1990a; Burns, 1978). By appealing to the fundamental wants and needs of followers, transactional leaders can apply rewarding or punishing behavior, depending on the context, to achieve desired outcomes (Bass, 1990a; Seltzer & Bass, 1990). Generally this type of leadership is not seen as effective in the long term as it ensures compliance, due to a desire to achieve individual interests rather than a shared vision, but does not generate commitment or enthusiasm among followers (Bass,

1990b; Burns, 1978; Kent et al., 2001). The theory is often equated with management due to its reliance on conformity to goals rather than challenging organisational boundaries, and an assumption that the leader possesses formal authority allowing them to exert punishment or rewards on followers (Bass, 1990b).

Transactional leadership is often seen as poor and ineffective leadership. In contrast, transformational leadership is generally regarded as one of the most effective leadership styles, relying on leaders encouraging followers to work towards a collective vision, motivated by elevated moral goals (Avolio & Bass, 1995; Bass, 1990b). Transformational leaders are expected to behave in an exemplary fashion, which followers are encouraged to emulate, encouraging transformational behaviour throughout the system (Bommer, Rubin, & Baldwin, 2004; Jung, Yammarino, & Lee, 2009; Yukl, 1999).

The new leadership theories conceptualise management and leadership as distinct processes, with leaders personifying transformational characteristics, and managers employing transactional techniques (Kent, 2005). Comparisons between the two approaches have demonstrated that transformational leaders engender higher levels of employee satisfaction than transactional managers, as well as increasing levels of organisational innovation (Avolio & Bass, 1995; Berson, Shamir, Avolio, & Popper, 2001; Jung, Chow, & Wu, 2003). These results have been replicated across multiple cultures and organisations; supporting the assertion that outstanding leadership relies on transformational behaviour (Den Hartog, House, Hanges, Ruiz-Quintanilla, & Dorfman, 1999; Dorfman & Howell, 1997). Across all these different contexts, the key to effective transformational leadership was seen as charismatic behaviours which are needed to encourage increased follower performance (Jung et al., 2003; Kent et al., 2001).

Charismatic behaviours are often seen as synonymous with transformational leadership, and involve leaders acting as a role model for the beliefs and values they want others to adopt (Howell & Shamir, 2005; Hunt, 1999). In this approach, leaders again rely on their characteristics

or behaviours, which are seen as 'special', elevating them above their group of followers, identifying them as somehow intrinsically different (Burns, 1978; Yukl, 2006). Charismatic leaders have often been negatively associated with cults and extreme religious factions, often due to the unquestioning nature of followers or the unconventional methods used by leaders to challenge organisational barriers (Bass, 1990a; Calas, 1993). However, when explored in less extreme circumstances, charismatic leadership is consistently linked to measures of effective leadership and increased organisational performance (Agle, Nagarajan, Sonnenfeld, & Srinivasan, 2006). Charismatic behaviours are seen as an essential component of transformational leadership, as individuals need to be elevated above the group and viewed as role models in order to achieve influence (Bass, 1990b; Howell & Shamir, 2005; Seltzer & Bass, 1990).

Despite the importance of the charismatic element of transformational leadership, recent work has suggested that portraying effective leadership as 'transformational' is too narrow and simplistic, arguing that transformational leadership can be exhibited in three distinct styles: charismatic, ideological, and pragmatic (Mumford, Antes, Caughron, & Friedrich, 2008; Strange & Mumford, 2002). The three approaches differ in the type of vision they present, and the way they attempt to influence their followers depending on the context, subsequently allowing leaders to adapt their transformational behaviour in different situations to achieve organisational success (Bedell-Avers, Hunter, Angie, Eubanks, & Mumford, 2009; Bedell-Avers, Hunter, & Mumford, 2008). Charismatic leaders are defined as focusing on a future vision which is emotionally evocative, ideological leaders focus on traditional and historical values, whilst pragmatic leaders focus on the functional needs of the organisational system (Bedell-Avers et al., 2009; Strange & Mumford, 2002). The distinction between the three types of transformational styles acknowledges the contextual influence on leadership, and the way perceptions of effective leadership behaviours will alter accordingly. This enhances the ability of leaders to act contingently and be effective, at least in theory.

2.3.3   Problems with New Leadership Theories

Despite a reliance on new leadership theories in existing research, there are problems with the theoretical framework, often relating to a continued lack of contextual consideration. As outlined above, the three types of transformational theory offer an opportunity for leaders to adapt their behaviour and transformational style according to different situations. However, in practice this aspect is often neglected and transformational theories rely increasingly on individualistic assumption. This is accentuated by the proliferation of individual psychometric testing, such as the Multifactor Leadership Questionnaire (MLQ) to determine individual ability and traits, rather than a more contextual approach (Avolio, Bass, & Jung, 1999; Schriesheim, Wu, & Scandura, 2009; Tejeda, Scandura, & Pillai, 2001).

Whilst transformational leadership has been criticised for being poorly defined, with significant overlap and lack of distinction between charismatic and transformational styles (Bryman, 1999; Yukl, 1999), it is the 'heroic' nature of the transformational leader which causes the most conceptual problems. Leaders are supposed to behave in way that exemplifies the values and ideals followers are supposed to aspire to, but where do these visions come from? Are they generated only by one individual or from mutual influence? The potential for reciprocal influence between follower and leader is also neglected in this model, which focuses only on the ability of the leader to influence or 'transform' others (Yukl, 1999). Transformational effectiveness is subsequently reduced to leader-centric understandings of personal characteristics, without further consideration of organisational or group processes (Howell & Shamir, 2005).

These theories rely on individualistic conceptions of leadership which attribute organisational effectiveness and success to actions of individual, formal leaders positioned within the organisational hierarchy. These assumptions are not reflected in the reality of modern organisations, which rely on multiple informal and formal leaders working within networks rather than hierarchies (Bryman, 1999; Mehra, Smith, Dixon, & Robertson, 2006; Yukl, 1999,

2008). The potential contributions of transformational theories are undermined by assumptions about the existence of clearly defined leaders, followers and common goals (Drath et al., 2008). As a result, the research produced does not provide an inclusive understanding or description of leadership as a complex, social process.

2.3.4   Post-Transformational Approaches: Leadership in Context

Existing leadership theories are therefore unsatisfactory in their consideration of the leadership process, attempting to examine it in isolation as a fixed, individual event. As previously identified, if leadership is an abstract, discursive mechanism used to explore organisational phenomenon, our understanding of it is reliant on the context in which the process occurs (Fairhurst, 2009; Heracleous & Hendry, 2000). Perceptions of leadership effectiveness and expected leadership behaviours will be significantly influenced by the context in which they are occurring (Johns, 2006; Lord, Brown, & Harvey, 2001a). Consideration of the leadership context therefore needs to extend to all organisational levels, rather than the individual or dyadic level, to consider the emergent, non-linear processes which will influence and be influenced by leadership processes (Hunt & Dodge, 2000; Morgeson & Hofmann, 1999; Uhl-Bien & Marion, 2009).

Contextual influences are particularly important in modern organisations which can be defined as 'pluralistic', denoting an organisation with multiple objectives, distributed leadership and a knowledge-intensive work force (Denis, Langley, & Rouleau, 2007). Consisting of multiple, overlapping hierarchies and networks of teams, these organisations encounter more vertical, hierarchical and spatial complexity than linear, hierarchical organisations which traditional leadership theories are based on (Anderson, 1999; Lichtenstein & Plowman, 2009; Uhl-Bien et al., 2007). This complexity makes the reliance on one leader in a vertical leadership role unfeasible, meaning that organisational vision and change is driven by multiple formal and informal leaders at different hierarchical levels (Lichtenstein & Plowman, 2009; Pearce et al, 2007). This emergent, distributed leadership should subsequently encourage adaptive change

21

and organisational innovation, increasing organisational performance (Basadur, 2004; Heifetz, Grashow, & Linsky, 2009).

2.3.5 Distributed Leadership

Theories of distributed, or shared, leadership reflect the increasing importance of team processes in organisations as they move away from traditional hierarchies towards flatter organisational designs (Avolio et al., 2009; Day et al., 2006). Distributed leadership approaches suggest that multiple individuals can take on positions of leadership within a group or organisation in an emergent, informal fashion, rather than being appointed to formal positions of leadership (Carson et al., 2007; Day et al., 2004). This shared, informal approach allows the roles of leaders and followers to become blurred, with individuals taking on informal leadership positions in a temporal and contextual process responsive to team needs (Collinson, 2006; Day et al., 2004; Friedrich, Vessey, Schuelke, Ruark, & Mumford, 2009).

The emergence of leaders throughout the organisation creates a series of informal networks, leading to an innovative and creative environment (Marion & Uhl-Bien, 2001). The existence of leaders dispersed throughout the hierarchical system drives responsibility downwards throughout the organisation, encouraging leadership behaviours amongst all organisational members, increasing commitments, innovation and positive organisational change (Gronn, 2002; Marion & Uhl-Bien, 2001; Pearce, Manz, & Sims Jr, 2008). There is also a strong consensus that distributed leadership increases team performance, member satisfaction and results in a more powerful and influential collective vision than one imposed top-down by formal leaders (Dionne & Dionne, 2008; Friedrich et al., 2009; Pearce et al., 2007). Formal leaders still exist within the system, but they are responsible for empowering informal leader emergence and maintaining a stable and strong team environment (Friedrich et al., 2009; Hiller, Day, & Vance, 2006; Pearce, 2006; Pearce et al., 2008; Zaccaro, Rittman, & Marks, 2001).

Empirical links between distributed leadership and organisational performance have found it to be more beneficial than the more traditional, vertical leadership frameworks (Ensley, Hmieleski, & Pearce, 2006; Pearce & Sims Jr, 2002). Effectively combining informal and formal vertical leadership has great potential for positive organisational and individual outcomes. However, application of the approach in practice can be complex. The interaction between top-down and bottom-up informal, emergent influences can cause significant tensions, and distributed leadership can be extremely limited if formal leaders do not empower the emergence of informal leaders throughout the organisational system (Bolden, Petrov, & Gosling, 2009; Carson et al., 2007; Currie, Lockett, & Suhomlinova, 2009a)

2.3.6   Problems with Distributed Leadership Theory

Distributed leadership is an increasingly popular theory, particularly in the UK public sector, where the educational and health sectors consist of increasingly complex networks, overlapping hierarchies and multiple professional groups (Harris, 2007; Martin, Currie & Finn, 2009). Despite the potential benefits of a distributed approach to leadership, the model is underdeveloped and the concepts are poorly defined, with distributed or shared leadership used interchangeably as rhetorical devices, or analytical frameworks, rather than clear models (Bolden et al., 2009). There are a number of elements of distributed leadership which require further consideration.

If leadership and power are distributed at multiple levels throughout an organisation, problems may arise due to conflicting visions of emergent leaders, resulting in a potentially destructive and chaotic environment (Schneider & Somers, 2006). To prevent this from occurring, strong informal and formal networks are required to coordinate leader actions and ensure formal and informal leaders are working towards overarching organisational goals and strategic visions (Denis et al., 2007; Mehra et al., 2006; Yukl, 2008). It is not clear how this occurs, neither have the impacts of potential conflict between distributed and formal leaders been considered, particularly with regards to the way in which formal leaders are able to relinquish power and control within the organisational system (Balkundi & Kilduff, 2005; Harris, 2007; Regine & Lewin, 2000). These issues are further areas for empirical research, but perhaps the most

pressing research focus needs to be on the contextual factors and antecedents influencing the development of distributed leadership (Harris, 2007; Pearce & Sims Jr, 2002).

The most fundamental antecedent to distributed leadership, and one which is relatively ignored in the existing literature, is the impact of identity on leadership. It is noted that distributed leadership will only occur when a strong group identity exists, and team members are motivated and willing to offer and accept informal leadership (Carson et al., 2007; Gronn, 2002). The antecedent of an identity which is conducive to leadership, and the acceptance of informal leaders by other members of the group, are elements of leadership theory which have been poorly considered in the existing leadership research.

2.4   Antecedents of Leadership – The Identity Problem

Most leadership theories discern between the role of 'follower' and 'leader'. The majority of studies rely on follower perceptions to understand leadership effectiveness, making their role a particularly important one to understand. Despite this reliance, the leader-centric nature of existing theories has meant that the influence of followers has been neglected and being labelled a 'follower' has low status, passive and negative connotations (Bjugstad, Tach, Thompson, & Morris, 2006). In addition, the assertion that they are two distinct identities suggests the roles are mutually exclusive and static, assumptions rejected by more shared, distributed approaches to leadership (Bjugstad et al., 2006; Collinson, 2006). The impact of identity on leadership occurs at three levels: individual perceptions about leadership resulting from implicit leadership schema; group identity and conformity to prototype; and widely shared societal and cultural expectations.

Individuals will be perceived as effective leaders if their behaviours, skills or abilities match preconceived ideas held by followers about what constitutes leadership (Lord & Hall, 2003). Potential leaders rely on these implicit leadership theories for group acceptance when they

emerge from within groups, encouraging followers to identify them as leaders and follow their

proposed visions (Chemers, 2003; Chun, Yammarino, Dionne, Sosik, & Moon, 2009; Hogg, Martin,

& Weeden, 2003). These implicit leadership schema are developed through experience and

through socially developed expectations, leading to generalisable characteristics, such as

intelligence and charisma, which can be applied across different professional and social groups

(Epitropaki & Martin, 2005; Hall & Lord, 1995; Offermann et al., 1994).

Leadership emergence and perceived effectiveness will also be fundamentally affected by group

membership and a salient collective identity (Hogg et al., 2006; Van Der Vegt & Bunderson,

2006). The development of a collective social identity is important in leadership as it encourages

individuals to work towards a common goal, which prioritises group benefits over individual

aims (Hogg et al., 2003; Torpman, 2004). This is particularly influential for highly salient groups,

such as professions, which engender a strong sense of social identity, and in which leader

emergence and influence are particularly influenced by group prototype – a representation of the

values and ideals held by that social group (Hogg, 2001b). In these highly salient groups,

prototypical members are more likely to emerge as leaders and be seen as role models due to

their group identity, rather than any of their other qualities or leadership abilities (Chemers,

2003; Hogg et al., 2006; Hogg et al., 2003). As a result, individuals who emerge as leaders from

within the group will be viewed as more influential and successful than those who attempt to

impose leadership from outside the group, and who may not share the same social identity

(Platow, Haslam, Foddy, & Grace, 2003).

In addition to the expectations of group members, perceived leadership effectiveness will also be

influenced by widely held societal and cultural perceptions about the influence and power of

specific social groups according to categories such as race, gender or profession (Hogg et al.,

2006; Ridgeway, 2003). These social perceptions can have a significant effect on leadership

emergence and effectiveness when group prototypes are associated with stereotypical images

(Ridgeway, 2003). Social expectations will therefore have an impact on the potential power and

influence of respective groups, leading to the development of leadership hierarchies, where the

most socially influential leader will be viewed as the most legitimate (Collinson, 2006; Hogg, 2001b). This process of leader emergence, and its impact on the leadership potential of professional groups, is explored in more detail in the next chapter.

2.5 Conclusion

The lack of a clear, consistent definition of leadership has resulted in a multitude of conceptualisations and resulting theories, none of which fully encompass what it is to 'lead'. This has led to problems for researchers attempting to identify leadership effectiveness and subsequently measure the outcomes of this success. Through a critique of the existing leader-centric theories of leadership, I have clearly demonstrated that leadership cannot be viewed as an isolated, individualistic event, but as a social process. This process is embedded in social and organisational contexts, rendering traditional theories of leadership inappropriate when considering complex, pluralistic organisational processes. Distributed leadership approaches place leadership at all levels of an organisational system, encouraging informal leadership emergence through the fostering of a supportive organisational culture and system of networks to increase innovation. Whilst this approach would appear to be the most appropriate model of leadership to apply in pluralistic organisations, there are a number of antecedents to distributed leadership which have not been fully explored. The importance of identity for the emergence of leaders is perhaps the most influential of these antecedents, and one which requires further exploration. In the next chapter, I address the question of how identity will influence leadership.

3 Identity and leadership

3.1 Introduction

In the first literature review chapter I concluded that popular leadership approaches have not fully considered the impact of identity on leadership development and influence. In this chapter I propose a conceptualisation of identity as a product of social interaction (Goffman, 1959), using the Social Identity Approach (Haslam, 2004) to consider the impact of salient identities on the enactment of leadership, and particularly the importance of professional identity. Whilst existing research has focused on more traditional, powerful professions, such as medicine and law, whose identities are compatible with leadership, little work exists examining professions whose identities may not be compatible. I will primarily consider these groups, those traditionally subordinate to more powerful professions within the same organisational system. These professionals will struggle to emerge and be viewed as effective leaders, due to a discrepancy between their group prototype and commonly held implicit leadership schemas. This difficulty is seen amongst the nursing profession, where the paradoxical positions held by 'nurse leaders' offer an illuminating insight into the identity conflicts experienced by the subordinate professions attempting to construct leadership identities.

3.2 Theories of Identity

Identity cannot be seen as a stable, isolated entity, it must be defined and constructed through interactions with others, through discursive mechanisms and narratives in an ongoing process of self-reflection, adaption and construction, shaped by social interaction (Goffman, 1959; Lindgren & Wahlin, 2001; Wells, 2007; Schwalbe & Mason, 1996). This process is influenced by social structures, such as organisations, which act as discursive spaces in which identities are constructed to enable individuals to make sense of their collective group identifications and roles (Brown, 2006; Ibarra & Barbulescu, 2010). From a social constructionist view, organisations are sets of collective action, where individuals attempt to construct meaningful identities through narratives (Czarniawska-Jorges, 2010). Whilst identity cannot be fully interpreted through a

social constructionism agenda, due to an inability to account for events beyond our understanding or perception (Cerulo, 1997), it can be used as an insight into organisational phenomena when the reciprocal influence of social structures, individuals and audience on each other are acknowledged (Czarniawska –Jorges, 2010; Lindgren & Wahlin, 2001; Stryker & Burke, 2000). In this thesis I acknowledge the existence of a reality and events which occur beyond our understanding, but conceptualise identity as a reciprocal product of social interaction, constructed through identity work, with other individuals and within social systems.

Identity work is a term used to denote the group process by which individuals actively construct their identities, and consequently set about communicating and portraying that identity to themselves and others, through the creation of symbolic resources that give meaning to themselves and others (Pratt & Rafaelli, 1997; Schwalbe & Mason-Schrock, 1996; Watson, 2008, 2009). As acknowledged by Watson (2008), this is not primarily seen as an internal, self-focused process, but self-reflection and identity construction through discourse and narrative interaction with others, to clarify whom one is and is not. Narratives and rhetorical mechanisms are an important element of identity work, offering a reflexive approach to identity constructions which unfold over time and are embedded in a wider social and cultural context (Brown, 2006; Ibarra & Barbulescu, 2010). Within this context, people may simultaneously tell different stories to each other, enabling flexible presentations of the self (Goffman, 1959; Brown, 2006). This flexible presentation of the self has been acknowledged in previous work, where researches have gained increased understanding of how individuals use legitimating identity work to construct a desired outcome, and to achieve participation and influence within social groups by presenting appropriate identity constructions (Creed et al, 2002).

Narrative identity work is particularly illuminating when considering periods of identity change, often following macro-role transitions (Ibarra & Barbulescu, 2010). In addition to conveying a desired impression to an audience, identity work allows individuals to confront and resolve feelings of anxiety and confusion about their identity during these transitions, bridging the gap between old and new identities (Alvesson & Willmott, 2002; Ibarra & Barbulescu, 2010;

Schlenker, 2003; Sveningsson & Alvesson, 2003; Tice & Wallace, 2003). This bridging work, constructing temporary solutions to identity change, has been termed the construction of 'provisional selves' (Ibarra, 1999), a continuous and ongoing process of identity work and negotiation in order to internalise and stabilise a salient identity, acting as a buffer against potentially diverse or fragmented identity conflicts (Svennison & Alvesson, 2003). In this way, successful identity work can be used to sustain feelings of authenticity and reduce conflict (Ibarra, 2003). When identity work is unsuccessful, individuals will encounter emotional discomfort and feelings of inauthenticity, anxiety, insignificance and confusion (Ibarra & Barbulescu, 2010; Schwalbe & Mason-Schrock, 1996). Unsuccessful identity work also diminishes effectiveness in their role because individuals are failing to convey impressions or images which are congruent with the social role they are trying to fill (Goffman, 1959).

In addition to the role of individual identity work in the identity construction and revision process, social groups and organisational contexts also have an impact. The group context in which individuals are attempting to construct identities will define and confine the success or appropriateness of the resulting identity outcomes (Ibarra, 1999). Individuals will adapt their identity constructions depending on context, and as such an understanding of the social context of identity work is crucial (Svenningson & Alvesson, 2003). In some circumstances, the dominance of the organisational discourse can regulate identity construction in such a way that it promotes organisational control, as individuals are only able to construct identities within pre-determimed managerial discourses (Alvesson & Willmott, 2002).

In acknowledging the importance of organisational or social group context, it is also essential to discern between the two types of social selves: the individual and the member of a larger social collective (Brewer & Gardner, 1996). As Mead (1934) argues, it is critical to determine between the 'me', which is the adoption of collective attitudes and behaviors, and 'I', which is the way in which the individual responds to those attitudes (Mead, 1934). At the individual 'I' level, self concept is based on traits and motivated by self interest, whilst at the group level the collective self concept is based on prototype (the 'me') and motivated by group welfare (the 'we') (Brewer

& Gardner, 1996; Mead, 1934). Salient groups provide a frame of self-evaluation at the individual level, and attitudes towards others will be influenced by their shared, or not shared, common group identity (Brewer & Gardner, 1996). However, there will be tensions between the need to be an individual and the need to personify a collective identity. Balancing personal identities with demanding social, organisational and occupational identity demands can be problematic, as outlined by Kreiner & Sheep's 2006 work on Episcopalian Priests. They showed that, after professional socialisation, identity work is an ongoing process to negotiate and mediate the boundaries between their personal and social identity, between the 'me' and the 'we'. The way this is mediated depends on the salience of social category memberships. The way individuals develop a membership with these groups, and the way in which their personal identities become intertwined with their social identities, is better explained through the lens of the Social Identity Approach.

3.3   The Social Identity Approach

The term 'Social Identity Approach' is a discursive mechanism previously employed by Haslam (2004). It encompasses two theories, Social Identity Theory (SIT) and Self-Categorisation Theory (SCT), which together offer insights into the way individual identity constructions are intricately bound with their membership in different social groups. The approach can be used to examine and understand the group processes which encourage individuals to adopt and construct shared group identities and behave in a collective manner, as well as guiding the process of emergent leadership (Haslam, Oakes, Reynolds, & Turner, 1999; Hogg, 2001b; Turner, 1987).

Social Identity Theory (SIT) suggests that individuals will categorise themselves and others into demographic, social and cultural groups to define their position in the wider social system (Tajfel, 1978, 2010). The processes by which this occurs are defined as categorisation and self enhancement (Hogg & Terry, 2001b). Categorisation processes place individuals into multiple social groups, for example profession, gender or age, structuring the social environment and enabling individuals to define themselves and others according to their group memberships

30

(Ashforth & Mael, 1989). These groups are associated with widely held social stereotypes, which guide expected behaviours of group members, the perceptions of non-group members towards them, and highlight differences between group ideologies to maintain distinct characteristics (Montgomery & Oliver, 2007; Tajfel, 1981). These inter-group differences are highlighted through self-enhancement processes, whereby individuals internalise a strong and positive identity associated with their group membership, and conformity to group behaviours and shared values (Haslam, Ellemers, Reicher, Reynolds, & Schmitt, 2010; Hogg & Terry, 2001a). In this way individuals are categorised, both by themselves and others, into multiple, distinct, social groups. The stereotypes which exist within wider society subsequently act to maintain and legitimise the existing social structure and hierarchy, with groups perceived as either high or low status, influential or non-influential according to their group characteristics (Oldmeadow & Fiske, 2010; Tajfel, 1981). Conforming and displaying these stereotypes to others allows individuals to begin constructing a desired group identity.

Whilst SIT explains the way social groups are formed and maintained within a larger social structure, it does not consider the actions of individuals within those groups, or the processes they undergo to develop and construct a salient group identity. This understanding is offered from an exploration of Self-Categorisation Theory (SCT) which examines the intra-group processes, shaping shared values and encouraging collective action through individual conformity to the group prototype (Hogg & Terry, 2000; Turner, 1987). Group prototypes are conceptualised as the stereotypical or ideological aspects group members identify with and attempt to emulate, maintaining a distinctive group identity and protecting their unique sphere of influence through enactment of collectively accepted behaviours (Haslam et al., 1999; Hogg & Terry, 2000, 2001a). Individuals adopt prototypical behaviour through depersonalisation processes, transforming from idiosyncratic identities into representations of group prototype (Haslam, 2004; Turner, 1987). The important attempts to emulate group prototype create a perceived gradient of prototypicality within the group, with individuals who construct the most prototypical identities enjoying high levels of respect and social influence over other, less prototypical, members (Hogg, 2001a, b). As a result, individuals will initially emerge as group

31

leaders due to their conformity to group prototype and resulting influence over other group members, rather than as a result of their potential leadership skills.

3.3.1 Identity and Leadership

The Social Identity Approach provides an insight into the development and emergence of leadership within groups, framing it as a process of mutual influence amongst interdependent group members who engage in social interaction to construct prototypical identities (Haslam, 2004). As discussed above, salient group members will strive to be seen as prototypical, with the most prototypical individuals enjoying the highest levels of social group influence (Hogg, 2001b; Hogg & Terry, 2000). These highly influential group members are able to influence group decisions and behaviours, subsequently emerging as leaders as they affirm the distinctive group identity, and act as role models for other members to emulate (Haslam & Platow, 2001; Hogg, 2001b; Hogg & Terry, 2000).

As context changes, other prototypical members may take on leadership roles in a dynamic and response to changing prototypes or group expectations (Hogg, 2001c; Platow & van Knippenberg, 2001). Distributed or shared leadership is advocated and reinforced as a contextually responsive, effective method of leadership in groups. Whilst 'heroic' leadership theories perpetuate the image of special individuals who possess specific characteristics or skills attributed to their success, the social identity approach suggests that any individual can emerge from a group if they are representative of it, and are able to construct an appropriate identity (Haslam, 2004). In these salient groups, leadership effectiveness is related to how prototypical individuals are seen to be rather than their general leadership behaviour or ability (Hogg, 2001b; Hogg & Terry, 2000).

The importance of prototypical conformity can be problematic for emergent leaders, as the very act of identifying them as 'leaders' sets them apart from the rest of the group (Hogg, 2001b; Hogg & Terry, 2000; Platow & van Knippenberg, 2001). This elevation may result in disengagement

from group members and a loss of social attractiveness and influence, as leaders are no longer seen as prototypical (Hogg, 2001c). Additionally, prototypical group behaviour may not be perceived as appropriate leadership behaviours, reducing their influence within the wider social system and their potential to inspire change outside of their group (Fielding & Hogg, 1997; Haslam & Platow, 2001; Hogg & Terry, 2000). This is due to the widely held social stereotypes which are used to guide perceptions of leadership effectiveness and success by individuals from outside the salient identity group. These stereotypes, termed 'Implicit Leadership Theories' in the literature, are used by individuals to perceive and categorise others as 'leaders' or 'non-leaders' (Lord, Foti, & De Vader, 1984; Lord & Hall, 2003; Offermann et al., 1994).

Examining implicit leadership theories across multiple contexts and cultures has determined a number of characteristics consistently linked with perceptions of leadership: traits including sensitivity, intelligence, trustworthiness, being visionary, masculinity, and charisma (Den Hartog et al., 1999; Offermann et al., 1994). Despite the feminine attributes of some of these qualities, such as sensitivity, and the acknowledgement that feminine leadership styles can be extremely effective in modern organisations, group members with masculine characteristics have been demonstrated to emerge as leaders significantly more often than those with feminine characteristics, regardless of an individual's gender (Eagly & Johannesen-Schmidt, 2001; Offermann et al., 1994; Steyrer, 1998; Williams, 1992). I am not suggesting that men will be more effective than women in leadership positions, but that the characteristics they display will be perceived as masculine or feminine, and their leadership potential and effectiveness judged based on others' perceptions of this.

Implicit leadership theories will have an effect on the perception of leaders by individuals from outside the social group, who will identify successful or effective leaders through their conformity to expected cognitive schemas (Fielding & Hogg, 1997). Most important is the stereotypical assumption that leaders are individuals who have the influence to innovate and achieve change (Buckingham, 2005; Denis et al., 1996; Kotter, 2001). However, within the salient identity group, success and influence will be linked with prototypical conformity, rather than

leadership behaviours (Hogg, Hains, & Mason, 1998; Lord et al., 2001b). This reliance on prototypical behaviour for the emergence of influential group leaders can be problematic if that behaviour is at odds with implicit leadership theories. This discrepancy can result in poor or ineffective group leadership, a lack of legitimacy within the wider social environment, and with individuals from outside the group, and ultimately an undermining of the potential influence of the leader and their social group (Currie et al., 2010; Fielding & Hogg, 1997). The nature and effects of this potential conflict between discrepant identities is further illuminated when the context of leadership identity amongst professional groups is considered.

3.4   Professional Identity and Leadership

Association with, and membership of, a professional group can have profound effects on individual identities, as it influences the way individuals will construct their self-identity (Slay & Smith, 2011). Through the process of socialisation, individuals begin to conform to established group attributes, values and beliefs, and engage in collective actions associated with their professional role. Through this process, they adapt their personal identity to conform to established professional prototypes which are representative of the historic group ideology, constructing a professional identity (Ibarra, 1999; Moreland, Levine, & McMinn, 2001; Raz & Fadlon, 2006). Socialisation occurs throughout professional training and education, facilitating a commitment to a professional   identity, which individuals subsequently use to guide and legitimise their behaviour and define their self-identity (Becker & Carper, 1956; Brown & Lewis, 2011; Pratt, Rockmann, & Kaufmann, 2006). When this professional identity becomes highly salient, individuals will strongly associate their personal identity with their professional group membership, using this salient identity to guide their perceptual and behavioural responses in multiple social contexts outside of their professional domain (Ellemers, Spears, & Doosje, 2002; van Knippenberg, van Knippenberg, De Cremer, & Hogg, 2004). Professional identity can therefore be defined as a relatively enduring and stable self-concept based on the attributes, beliefs and values with which individuals define themselves in a professional role (Schein, 1978; Ibarra, 1999).

As previously acknowledged, the existence of widely accepted social stereotypes maintains and legitimises a status hierarchy within society, with groups perceived as either high or low status, influential or non-influential, according to their group characteristics (Oldmeadow & Fiske, 2010; Tajfel, 1981). This is particularly evident amongst professional groups, with traditional, historic professions such as medicine, law or accountancy, enjoying high levels of social influence and respect, due to their secure base of expert knowledge and legal jurisdiction (Abbott, 1988; Shortell, 1974). Individuals whose salient identity is bound up with lower status group membership occupy an interesting theoretical position, as the very nature of their sphere of influence, expertise and identity is shaped by, and relies upon, the maintenance of their subordination to more powerful groups (Abbott, 1988; Abbott & Meerabeau, 1998; Pratt & Rafaeli, 1997). This subordinate behaviour is at odds with the implicit leadership schemas discussed above which require leaders to influence, innovate and change, causing identity conflicts for individuals attempting to combine a subordinate professional and influential leadership identity. This paradox is particularly illuminated when considering the struggles of the nursing profession in their development and construction of influential leadership identities, offering an insight into how individuals resolve conflicts between their professional and leadership roles and identities.

3.4.1 The Professional Identity of Nurses

Throughout the last century nursing has developed from a relatively unskilled vocation to a profession requiring higher education, with its own research and knowledge base. Due to their front line, patient centred roles, nurses are ideally placed across a system of inter-disciplinary networks, giving them the potential to innovate and lead across different contexts in the organisation (Cummings et al., 2008; Graham, 2010; Hart, 2004). Despite this professional development, nurses as a professional group are still seen as occupying a relatively low social status, reflected in a lack of nursing leadership at strategic and political levels (Davies, 2004).

Existing work into the low status of the profession, and lack of effective nursing leadership, has attributed it to its close ties with medicine (Campbell-Heider & Pollock, 1987; Gjerberg & Kjølsrød, 2001; Tellis-Nayak & Tellis-Nayak, 1984). The relationship between medicine and nursing is well documented, with the dominance of the medical profession often regarded as limiting nurse leadership if it is perceived as challenging their professional jurisdiction (Chan, 2002; Currie et al., 2010; Diefenbach & Sillince, 2011; Finn, Currie, & Martin, 2010). Whilst it is evident that nurses do not enjoy the same respect or status as doctors, often relying on the medical profession to define their professional boundaries and levels of autonomy (Allen, 1997; Cameron & Masterson, 2000; Reeves, Macmillan, & Van Soeren, 2010), it would be over simplistic to assume this is the fundamental cause of the lack of influential nursing leadership. Within their clinical roles nurses exert strong, informal professional influence over patient care, medical decisions and treatments, and cannot be perceived as merely passive team members (Hughes, 1988; Svensson, 1996; Wicks, 1998). The cause of their lack of leadership influence within the wider organisational and social environment therefore lies elsewhere. It is a result of their prototypical identity, which is incompatible with expected leadership behaviours.

3.4.2 The Prototypical Nurse

The nursing group prototype continues to be dominated by images of Florence Nightingale, encouraging stereotypically feminine ideals of obedient, silent, altruistic and passive caring (Dingwall, Rafferty, & Webster, 1993; Goodrick & Reay, 2010; Mackay, 1989; Whittaker & Olesen, 1978; Williams, 1978). This stereotype is held throughout society, and perpetuated by the profession who, despite their increasing technical skills and academic education, continue to emphasise the focus of their role on the traditions' altruistic, patient focused values (Apesoa-Varano, 2007; Fagermoen, 1997; Öhlén & Segesten, 1998). This perpetuation of a societal stereotype, which expects nurses to act as demure, subservient handmaidens, is problematic in two respects. Firstly, it is not representative of modern, professional nurses, resulting in a discrepancy between their socialised identity and their expected role behaviours, leading to areas of potential identity conflict (Currie et al., 2010; SØRensen, Delmar, & Pedersen, 2011).

Secondly, it maintains the assumption that nursing behaviour is at odds with masculine, implicit leadership theories, reducing their potential congruence with a leadership identity or acceptance by individuals outside the professional group (Chua & Clegg, 1989; Eagly & Johannesen-Schmidt, 2001; Lord et al., 2001b). Nurses therefore face internal and external conflict when they attempt to lead.

Although this study is not primarily concerned with gender, it would be simplistic to fail to consider the impact of gender on the nursing profession, or on their perceived ability as leaders. Demographic attributes are often correlated with other identities resulting from social stereotypes, such as Caucasian male executives, or ethnic minority female maids and nurses (Ashforth & Johnson, 2001; Brickson & Brewer, 2001). These social categories will influence the ability of individuals to emerge and be accepted as leaders, based on their conformity to widely accepted assumptions about their identity congruence with the task at hand (Berger, Balkwell, Norman, & Smith, 1992). It is therefore necessary to acknowledge their potential impact on leadership.

Nursing is a predominantly female profession, with 90 per cent of the workforce made up of women, but it is often noted that men occupy a disproportionate amount of managerial and leadership positions within the profession (NHS, 2010a, 2012). This is, in part, due to the underlying societal assumption that men are better leaders and managers than women (Foddy & Smithson, 1999; Pullen & Simpson, 2009). This assumption is based on widely accepted implicit leadership theories, which suggest leaders need to display masculine, authoritative identities and behaviours (Keller, 1999; Offermann et al., 1994). These implicit leadership schemas are perpetuated in social systems, despite frequent assertions that feminine leadership styles can be more effective in modern organisations than the more traditional leadership approaches (Baxter, 2010; Eagly & Johannesen-Schmidt, 2001; Ford, Harding, & Learmonth, 2008; Lazzari, Colarossi, & Collins, 2009; Wilson, 2003). Nursing identities are orthogonal to this, as nursing is seen as 'women's work', reflected in media images and social expectations of nurses which seem to

suggest a 'good nurse' and a 'good woman' share many of the same qualities (Dingwall et al., 1993; Fealy, 2004; Whittock & Leonard, 2003).

The elevation of male managers over female nurses at the bedside also undermines the importance of nursing or therapeutic care, as men are seen as taking up more 'legitimate' and important hierarchical roles (Cross & Bagilhole, 2002; Porter, 1992; Williams, 1992). Despite this, it is not the high proportion of women to men within nursing that cause issues for identity, but the continuing construction of an identity stereotype which encourages feminine ideals and behaviours. Although they are seen as more appropriate managers due to their sex, male nurses will still struggle to exert leadership influence within the wider social and organisational system due to their professional identity (Budig, 2002; Davies, 2003; Whittock & Leonard, 2003). It is the innate femininity of the nursing identity which causes problems for potential nurse leaders, rather than their gender. Female doctors, perceived as being in a more influential profession characterised by masculine behaviours, will not struggle to exert leadership as much as nurses (Gjerberg & Kjølsrød, 2001). Nurses are therefore socialised into an identity which requires them to display traditional, feminine behaviours in modern roles which require more managerial and masculine behaviours. This forces them into a role which is incongruent with their salient identity, causing conflict as they portray behaviours orthogonal to those expected from their professional group.

In addition to the strong feminine stereotype in nursing, the very nature of nursing work creates problems for those attempting to take on leadership positions. Widely held social assumptions, compounded by media stereotypes, portray nurses as either young, angelic and altruistic girls, or as fierce matrons who act to protect the authority of doctors (Baggott, 1998; Hart, 2004). Nursing work is seen as more lowly than the highly skilled knowledge base associated with medicine, and the assumption that nursing is a poor second choice of career for those who have failed to become doctors perpetuates the relatively low social status of nurses, and devalues their professional contribution (Baer, 1997).

Perhaps one of the most fundamental challenges for nursing is to increase social awareness about the reality of their job. The 'invisibility' of nursing work has been acknowledged repeatedly in the literature, and the inability of nurses to concisely define what it is they offer to patient care seen as inhibiting their professional progression (Hemsley-Brown & Foskett, 1999). Much of nursing work is 'invisible', associated with 'caring' work which is difficult to define and measure (Beck, 1999; Woodward, 1997). The aspect of nursing work which *is* visible, such as issues relating to personal hygiene and working intimately with sick people, has led to a dichotomous social status for nurses. Whilst they are often praised for their caring and altruistic work, the dirty and intimate nature of that work can lead to the profession being undermined by a Western, sanitised society who value technical skills and do not highly regard work which is intrinsically feminine or 'dirty' (Apesoa-Varano, 2007; Fagin, 2000; Oldmeadow & Fiske, 2010; Salvage, 2006). In some cultures this social stigma is so profound that nurses are often equated with prostitutes and even excluded from society completely (Hadley et al., 2007). Although this level of disdain is not as extreme in Britain, the social stigma attached to the 'dirty work' of nursing still undermines the potential status and contribution of the profession (Ashforth & Kreiner, 1999; Hemsley-Brown & Foskett, 1999; Hogg, 2001c).

As mentioned above, the inability of nurses to define the rather abstract phenomenon of 'care', or their role in the caring process, makes it difficult for them to succinctly identify what their unique contribution to the health service is, except for in their subordination to medicine (Dingwall et al., 1993; Olson, 1997; Waugaman & Lohrer, 2000). This is compounded by a discrepancy between the commonly held nursing stereotypes and the reality of their modern day role (Fealy, 2004; Hughes, 1988). In an attempt to rectify the discrepancy between social stereotypes and the reality of their role, nurses have attempted to move towards a more professionalised status. This has primarily focused on a need to build a solid knowledge and research base, reflecting their unique professional jurisdiction which is separate from medicine (Allen, 2007). Paradoxically, the attempts to conduct 'scientific' research into the non-quantifiable area of nursing care have resulted in poor and limited studies, further undermining the contribution of nursing research

39

and compounding their low social appreciation (Baggott, 1998; Beck, 1999; Merkouris, Papathanassoglou, & Lemonidou, 2004; Morgan, Calan, & Manning, 1995). Nursing education is also often undermined, even as it moves towards and all-degree entry system (Martin, 2009; NMC 2010).

3.4.3   The Impact of Nursing Prototypes

Nurses are socialised into the profession's hierarchy, with implicit roles and values, taking on the institutionalised behaviours which perpetuate the subordinate nature of nursing prototypes (Fagermoen, 1997; Hart, 2004; Waugaman & Lohrer, 2000). Students are exposed to these prototypical identities through role models and practical learning experiences, encouraging them to conform to accepted behaviours and construct an identity compatible with group prototype, even when that is at odds with the reality of their modern role (Björkström, Johansson, & Athlin, 2006; Chua & Clegg, 1989; Fitzpatrick, While, & Roberts, 1996). This continuing identity conflict, perpetuated by the socialisation process occurring during professional training, undermines their leadership potential as nurses are already balancing multiple identities in their day-to-day roles.

The fundamental assumption that nurses are stereotypically subordinate presents challenges for the profession, as they struggle to be perceived as prototypical leaders of the health service by wider society (Hogg, 2001c; Hogg et al., 2003; Oldmeadow, Platow, Foddy, & Anderson, 2003). Those who are perceived to possess the stereotypical attributes to become leaders (i.e. White, male, physician) will be more influential and more likely to emerge as organisational leaders than those who do not (i.e.. Ethnic minority, female, nurse) (Jost & Elsbach, 2001). As a result, doctors are seen as possessing innate leadership ability and nurses are seen more as managers than leaders (Chan, 2002; Currie et al., 2010; Hall, 2005; Hean, Macleod Clark, Adams, & Humphris, 2006; Henderson, 2006; Jost & Elsbach, 2001). The salient nature of nursing prototypes are so complete that nurses will often remain passive and dependent on more influential groups, despite high levels of clinical expertise and hierarchical responsibilities

(Campbell-Heider & Pollock, 1987; Hallam, 2002). The perpetuation of social stereotypes of nursing, alongside intractable professional hierarchies, reinforces the perceived lower status of nursing within the organisational system and perpetuates the assumption that nurses are not effective or legitimate service leaders, due to their lack of influence and ability to exert change (Currie et al., 2010; Finn et al., 2010; Hall, 2005; Jost & Elsbach, 2001).

The lack of respect from society, the discrepancy between nurses' social identity and the negative perceptions of their role by the public, can lead to low self esteem and feelings of inferiority and powerlessness (Takase, Kershaw, & Burt, 2002). Nurses as a group do not feel confident in their leadership ability and will act in self-limiting ways. The culture of nursing as a professional group does not encourage leadership, and nurse leaders are not respected as they are no longer seen as prototypical of the group and will struggle to exert influence (Charles-Jones, Latimer, & May, 2003; Currie et al., 2010; McKenna et al., 2004; Miers, 1999). Doctors use their high occupational status to command respect and influence within the organisation, whilst nurses are resigned to their lower status positions and will actually act to perpetuate them in order to protect their unique professional contribution within the context of a subordinate role (Jost & Elsbach, 2001; LaTendresse, 2000). Within the NHS, an organisational system that still relies on hierarchical leadership of teams, rather than participative leadership, nurses struggle to emerge and be accepted as legitimate leaders as they are not stereotypically appropriate (Campbell-Heider & Pollock, 1987).

Nurses who do take on positions of leadership or managerial responsibility are acting outside of their prototypical roles, and this incompatible behaviour often leads to criticism from society and other professions (Bojtor, 2003; Bolton, 2005). However, the NHS is increasingly focused on business outcomes, requiring clinicians to take on increasingly managerial positions which will force them into these non-prototypical roles (DOH, 2008). This discrepancy between their professional identity and professional role can force nurses into paradoxical positions, causing internal conflict as they attempt to align their historical group ideology with their modern role demands (Apesoa-Varano, 2007; Cott, 1998; Pratt & Rafaeli, 1997). These overlapping, often

contradictory discourses (traditional professional versus managerial), cause identity contradictions which exist in tension with each other (Brown, 2006), causing problems for individuals attempting to construct a legitimate nursing leadership identity.

3.1 Leadership Development and Identity Construction

Thus far, I have considered the influence of salient professional identities on the development and construction of a leadership identity, with a particular focus on the nursing profession whose prototypical identity is at odds with implicit leadership theories. I now consider the mediating influence of leadership development programmes as an arena of identity change and construction, and a mechanism by which organisations can facilitate the resolution of potential identity conflict of leaders. Leadership development programmes are seen as a crucial strategic development area in the NHS, touted as the answer to increased organisational innovation and success (Darzi, 2008; DOH, 2008a, b, 2009c; Hirst, Mann, Bain, Pirola-Merlo, & Richver, 2004). The specific nature of the leadership development programmes offered by the NHS are discussed in the next chapter, in this section I only consider them with regards to their potential influence on identity transitions.

Traditionally, leadership development approaches have focused on the skills and technical tools required by individuals to 'lead', criticised for being part of the 'tick box exercises' prevalent in public sector organisations (Day, 2000; Hirst, Mann, Bain, Pirola-Merlo, & Richver, 2004; McGivern & Ferlie, 2007). The outcomes of these approaches are relatively ambiguous, compounded by a reliance on an individualistic model of leadership and an assumption that leaders are heroic individuals (Avolio & Gardner, 2005; Barker, 1997). More recently the importance of identity transition and construction during the leadership development process, rather than skills and behaviours, has come to the fore (Carroll & Levy, 2010; Lord & Hall, 2005). Many now see identity transition as the central focus of leadership development, with the construction of a salient leadership identity advocated as crucial for the on-going success and further development of a leader (Day & Harrison, 2007; Lord & Hall, 2005). Addressing issues of

identity, rather than preparing individuals for specific tasks, is advocated as more effective for those moving into roles which may be ambiguous, or framed by a complex and dynamic organisational context (Edmonstone & Western, 2000).

Organisations offering leadership development programmes have the opportunity to provide an arena in which individuals can develop their leadership identities. Whilst previous work has considered this as a means of organisational control (Alvesson & Willmott, 2002), I would suggest it may also be a way in which organisations can facilitate and attempt to resolve the identity conflicts encountered by new leaders. This is supported by Carroll & Levy (2010) who suggest the leadership development space offers a way in which multiple identity narratives can coexist. The resulting struggles, tensions and anxiety force individuals to engage in identity work, developing their existing identities and creating new ones through social interactions with others.

The purpose of leadership development can therefore be conceptualised as an arena in which to challenge, develop and construct leader identities. Successful leadership development enhances the congruence between the demands of the leadership role and the salient identity of the potential leader. This identity transition takes place over time, as leadership roles, values and demands become integrated with the pre-existing salient identity, meaning that expert, fully developed leaders are able to integrate all aspects of their personal self into their managerial or leadership roles, moving from a multiple identity construction to an integrated one (Day & Harrison, 2007; Lord & Hall, 2005; Lindgren & Wahlin, 2001).

For those individuals with highly salient professional identities, such as clinicians, leadership development programmes have been conceptualised as arenas in which individuals should be able to build a leadership identity alongside their professional identity, constructing a hybrid identity (Williams, 2004). However, whilst this potential benefit of leadership development is acknowledged in theory, in practice it is unclear how successful this identity change will be, as

many professionals tend to revert back to their ingrained salient identity when challenged or faced with an ambiguous emerging identity (Carroll & Levy, 2008; Williams, 2004). The ability to fuse two competing identities together within a leadership development space also relies on a supportive organisational environment which offers individuals the freedom and creativity to do so (Carroll & Levy, 2010). The potential for this type of leadership development is considered in the next chapter, where I explore the organisational context of the NHS and the resulting impact on the development of leadership identities amongst clinicians.

3.2   Conclusion

In this chapter I have considered identity as a socially constructed phenomenon, highlighting the impact of social identity, and particularly salient professional identity, on potential leadership development and identity construction. Whilst most existing research has focused on more traditional professions which are congruent with leadership images, the identity conflicts encountered by subordinate professionals have not been considered. I examined the origins of this conflict from the perspective of the nursing profession, where a problematic group ideology and prototype, relying on passive, altruistic and feminine characteristics, were identified as barriers to leadership development and successful identity construction. Nursing ideologies and widely accepted social stereotypes are at odds with implicit leadership theories and the expected behaviours of leaders. Despite this, individuals from subordinate professions often take on positions of managerial leadership, with varying success. How subordinate individuals experience identity conflict when they move away from group prototype, and how these conflicts are resolved, is unclear. Whilst the mediating influence of leadership development programmes may encourage the resolution of identity conflict and create a space in which individuals can construct new identities, the ability of nurses to achieve this within their professional and organisational cultures is also unclear. These are questions which I intend to address in this thesis, in order to further explore and understand the influence of professional identities on leadership processes. However, before the impact of identity can be assessed, a comprehensive

understanding of the organisational context within which the leadership processes are occurring is required.

4 Leadership and the Organisational Context

4.1 Introduction

In order to examine identity construction and leadership among nurses it is crucial to understand the organisational context and discourse environment framing their development. Public sector organisations in the UK have undergone dramatic changes over the last 30 years, as attempts have been made to transform them from large hierarchical organisations under central government control to more devolved networks of organisations, which theoretically have more local autonomy. These administrative changes began in the 1980s, in response to a an emphasis on the need to end the overwhelming, self-serving power of professionals within public services, by increasingly involving citizens in the provision of services, and introducing competition and private management techniques to achieve growth and efficiency (Hood, 1991; Lynn Jr, 1998; Osborne & Gaebler, 1992). These reforms were termed 'New Public Management' and formed part of a 'managerialism' trend in the public sector, aimed at increasing efficiency and effectiveness through management techniques. More recently, managerialism seems to be giving way to 'leaderism' (O'Reilly & Reed, 2011), a focus on the importance of leadership in public organisations to achieve system-wide change.

In this chapter I will briefly outline the organisational evolution of the National Health Service since its inception in 1948, focussing primarily on the dramatic changes it has undergone in the last 30 years, as it has moved from a system of professionalism, to managerialism and finally towards an assumption that leadership is an organisational panacea (Currie, Boyett & Suhomlinova, 2005). Considering recent policies and attempts at organisation reform focussing on the importance of strong leadership, rather than management (Darzi, 2008; DOH, 2009), I will explore the tensions inherent within the organisational structure and culture of the NHS, and frame the organisational position of potential nursing leaders, illuminating the structural, cultural and professional issues they may face when attempting to construct a legitimate identity.

4.2   Public Administration and the Inception of the NHS

On the 5th July 1948, the National Health Service (NHS) was established, creating an administrative structure to provide free, universal healthcare to all British citizens (Klein, 2001). Since then, the NHS has grown to become the largest, and arguably most important, public sector organisation in the UK, and subsequently the one which has undergone the most organisational reforms since its inception. The service began as a monolithic centralised hierarchy, with each hospital under control from a management team generally consisting of a Medical Chairman, Matron and Administrator (Edwards, 1995). Power within the Public Administration system lay with relatively autonomous professionals, whose ability to influence others was related to professional competence, as well as hierarchical status (Sehested, 2002). Doctors in particular exerted strong professional leadership over the administrative system, holding authority over other clinicians, patients and 'administrators', an authority that was clearly enforced by their presence on hospital boards, allowing them to veto any managerial proposals they did not agree with. O'Reilly & Reed (2011) conceptualise this organisational state as one of 'professionalism', where the autonomy of professionals is prioritised and protected from non-professional influence, creating a system which is difficult to change or in which to challenge professional jurisdiction.

From the 1970s, a growing feeling of discontent with professionalism and the Public Administration structure of the NHS emerged. The public were becoming increasingly dissatisfied with the NHS due to their increasing expectations of the public services (Ferlie & Fitzgerald, 2002; Klein, 2001). The NHS was seen as unsatisfactory due to the strong central control of the bureaucratic hierarchy, which resulted in the Government passing down policies without consultation with other stakeholders. This led to the system being condemned as slow, inefficient and unresponsive to public need (Dawson & Dargie, 2002; Hood, 1974; Hughes, 2003; Lane, 2002). Professionals, and particularly doctors, were seen as acting in their own, rather than patient interests, and administrators were often seen as inefficient and unable to achieve service change due to the existence of strong professional control, which was obstructive to organisational change (Pollitt, 1993). Although central government would pass down advice and

guidance to hospitals, at local levels professionals often ignored this advice, exercising strong influence over the running of the hospital. Doctors exerted their authority at all levels of the NHS, achieving a right of veto over policy agenda and budgets, and determining and assessing outcomes for their own services (Klein, 2001). Senior doctors and matrons reportedly saw administrators as ineffective, often bypassing them and using professional influence to achieve organisational change, compounding the administrators' inability to exert organisational reform (Edwards, 1995).

The unquestioning professional authority of senior doctors could no longer be accepted and severe organisational reform was needed. The lack of cooperation between senior medical and nursing staff and administrators led to fragmented patient care, which was inefficient and often of a poor standard (Edwards, 1995). A report into administrative structure of the NHS (Griffiths, 1983) identified a severe lack of central guidance or control, a lack of evaluation about services, performance or economic efficiency, and a clear lack of administrative leadership. The answer, it proposed, was clear general management, free from central control, which could devolve responsibility down throughout the system. Dramatic organisational reform followed, with responsibility and authority being transferred from clinicians to general managers (Flynn, 2004). 'Professionalism' gave way to 'managerialism' (O'Reilly & Reed, 2011), advocating private sector techniques, reduced professional control, competition and the search for efficiency. Whilst administrators under the professionalised system were concerned with enforcing laws and regulations, managers were concerned with inciting change to ensure maximum efficiency and responsive resource allocation (Keeling, 1972).

4.3   New Public Management and the NHS Reforms

In a response to the need to reform the 'professionalised' state of the NHS, which was seen as prioritising professional needs over patient needs, competitive markets, consumer choice, rigorous auditing measures and private management techniques were introduced (Benington, 2000; Blair, 1999; Kakabadse, Korac-Kakabadse, & Kouzmin, 2003). These overlapping reforms

were seen as crucial to modernise public sector organisations, and the set of ideological concepts involved were termed 'New Public Management' (NPM) Hood (1991). These concepts are outlined in Table 1, and broadly encompass the need to cut costs and improve quality by a move towards managerial, rather than professional, power (Ferlie & Steane, 2002; Hood, 1991; Osborne & Gaebler, 1992).

Table 1: Hood (1991) Definition of NPM	
Concept	**Meaning**
Professional Management	Clear, visible control and accountability, no diffusion of power
Performance Measures and Standards	Defined, quantifiable goals and outcomes which helps measure accountability
Emphasis on Output	Resources and budgets are linked to performance outcomes, results are more important than process
Decentralisation	Breaking down large units, decentralising public sector budgets, separating provision and production
Competition	Contracts and competitive tendering to decrease costs and increase standards
Private Sector Management Practice	Hiring and recruiting from the private sector, using 'proven' management techniques
Resource Budgeting	Cutting costs, achieving better outcomes with less resources

The influx of 'managerialism' into the NHS began in the late 1980s, first with the introduction of internal competitive markets, then followed by reforms aimed at making the NHS more efficient, responsive and outcome focussed (DOH, 1989; Warwick, 2007). Managerial reform, driving modernisation throughout the organisation, was touted as the answer to the 'mediocrity' of the current public sector services (Blair, 1999). The need to develop a more 'business-like' NHS was seen as paramount for the survival of the organisation, resulting in increased focus on

performance standards, resource allocation, decentralisation and a greater consideration of patient needs through consultation with service workers (DOH, 1997, 2000).

Problematically, a reliance on the importance of managerialism for modernisation also resulted in the idea that private sector values needed to be adopted by public sector organisations (Pollock, 2005), and the assumptions that the principles of NPM were directly transferrable across sectors. The NPM reforms in the NHS relied heavily on the generic transfer of private sector management practices to the public services, and managers in the NHS were encouraged to use private sector management styles in order to appear credible (Blair, 1999; DOH, 2000). Despite these assertions, many of the models and theories developed in private companies have been condemned as narrow and inappropriate in the context of the health service, where an increased focus on achieving government standards and measuring pre-determined outcomes can detract from responsive patient care (Hunter, 1996; Pollock, 2005; Wilkinson, 1995). This sentiment has particularly been voiced by clinicians, who have often acted negatively towards the 'managerialism' reforms, and have been obstructive in the reform process (Griffiths & Hughes, 2000; Harrison, 2004).

As discussed above, the NPM reforms moved the NHS from a system of professional control and autonomy, towards one of managerial control where professionals were forced to conform to standardisation and measureable outcomes (Broadbent & Laughlin, 2002). These performance measures are often opposed by professionals, who report feelings of low job satisfaction and staff morale due to the perceived undermining of their professional autonomy (Broadbent & Laughlin, 2002; Gray & Harrison, 2004; Hoggett, 1996). Managerialism in the NHS is often treated with distrust and suspicion by professionals, accompanied with increasing demoralisation and feelings of powerlessness of public sector professionals, and a growing sense of disillusion and cynicism that political promises are often rhetorical or cyclical, and not realised in practice (Ahmad & Broussine, 2003; Christensen & LÆGreid, 2003; Pollock, 2005).

Problematically, professional opposition to managerial reforms can be extremely obstructive for modernisation attempts, due to the large levels of informal authority individuals enjoy at local levels, where they regulate the nature and pace of change. Doctors remain particularly influential in determining which reforms and targets are adopted by local hospitals, and can be disruptive by continuing to bypass managers they see as ineffective, echoing the problems of public administration (Currie & Suhomlinova, 2006; Klein, 2001). Resistance to reforms can prove most problematic when professionals feel split between their accountability to their patients and acting in public interest, whilst being politically accountable by implementing government policy they may see as misguided or misrepresentative of service demands (Hoque et al., 2004; Kakabadse et al., 2003; Pollock, 2005). This often results in conflict between managers and professionals in battles for authority, and can be detrimental to innovation or change events (Hoque, Davis, & Humphreys, 2004; McNulty, 2003). Existing endogenous conditions at local sites are difficult to change, particularly when professionals are not involved, as professionals can be particularly obstructive to organisational change and reform (Ferlie, Fitzgerald, Wood, & Hawkins, 2005; McNulty, 2003).

Subsequently, involving professionals has more recently been acknowledged as a fundamental element in ensuring conformity to attempts at reform and modernisation, and an acceptance of managerial control. Due to the large amount of influence held by professionals in the public sector, in both formal and informal settings, the need to involve them in organisational decisions and processes is seen as increasingly important (Benington, 2000; Kim, 2002). In the NHS, this is reflected in policies advocating a move away from managerial control, towards distributed, professional leadership, and the increased need for professional-manager hybrids (Darzi, 2008; DOH, 2010, 2011).

4.4   Post New Public Management and the need for Leadership

O'Reilly & Reed (2011) claim that the professionalism which characterised the Public Administration structure of the NHS was weakened by the introduction of managerialism, but the

continuing commitment of public service professionals to their occupational cultures and identities made reform difficult, due to their rejection of modernisation attempts. 'Leaderism' is conceptualised as a hybrid state between professionalism and managerialism, reducing the tensions between politicians, managers and professionals by unifying them in their role as service leaders (O'Reilly & Reed, 2010; 2011). As such, leadership is seen as crucial for modernisation and improvement, in particular emergent and distributed leadership alongside those in formal positions (Hartley & Allison, 2000).

It is this understanding which guides modern NHS reform and policy, placing central importance on the need for formal and informal professional leadership, creating networks within and between organisations, allowing professionals to be involved in more organisational decisions and processes (Darzi, 2008; DOH, 2009c; NHS, 2010b). Networks are advocated as important mechanisms in improving outcomes, generating diversity and increasing information sharing (Ferlie & Pettigrew, 1996; Kiljn, 2005). By acting as an arena for distributed leadership, networks can promote decentralisation and increase innovation through strategic positioning of expert, local knowledge (Bhatta, 2003; Jackson, 2001; Kernaghan, 2000; Martin et al., 2009; Silvia & McGuire, 2010; Agranoff, 2006; Brass, Galaskiewicz, Greve, & Tsai, 2004).

The need for distributed, clinical leadership in the NHS is championed in a number of key policies (Darzi, 2008; DOH, 2010, 2011c; NHS, 2010c). The Darzi (2008) report, in particular, highlighted the importance and organisational need for all clinicians to work as leaders at all hierarchical levels of the service, giving them opportunity to enhance their individual provision of care, as well as that of the organisation and the NHS as a whole. Four principles were suggested for empowering clinicians to lead and make service changes alongside managers (Table 2).

Table 2: Empowering NHS Professionals (Darzi, 2008)	
Proposition	**Why**
Freedom at the front line	Clinicians free to use their expertise, skills and creativity can find innovative ways to improve patient services
Strong Accountability	Setting free organisations from central control by creating stronger accountability
Empowering Staff	Giving medic and nurse managers authority and control over local budgets and resources to meet local patient need
Fostering Leadership	Change needs leadership. High quality care will not be achieved without it

Darzi (2008) signalled a shift of emphasis from managerial to clinical leadership, highlighting the importance of innovation and leadership over management. Although championed as the answer to public sector effectiveness, and alluded to in multiple government documents, the definition or model of leadership being used is never clearly defined. However, what is clear in the report is a need for the distribution of leadership and empowerment of clinicians to enact leadership at all levels, a theory advocated as crucial for the effective running of complex, dynamic organisations and in achieving complex and innovative change (Buchanan et al., 2007; Denis, Lamothe, & Langley, 2001; Hartley & Allison, 2000). Distributed, emergent leaders dispersed throughout the whole political and administrative context face unique challenges due to conflicting objectives, reinforcing the need for collaborative leadership networks and collective working (Denis et al., 2005; Lawler, 2008). Although not overtly stated, some degree of distributed leadership has been occurring in the public sector for years, as successful Chief Executives in the NHS empower others to foster and promote organisational change, treating leadership as a temporal, transient role which can be passed from one individual to another to meet organisational need (Hartley & Allison, 2000).

4.4.1   'Liberating the NHS'

Over the course of this study (which ran between 2009 and 2012) the NHS was exposed to dramatic organisational and structural changes. A change of government in 2010, coupled with

the lasting effects of the international financial crisis, had significant impacts on the organisational context of healthcare leadership and subsequent ramifications on the potential for and constraints of identity constructions. Before 2010, political commentators were becoming increasingly clear that the survival of the NHS relied on improvements to increase productivity, reduce budgets and decrease managerial spending (Appleby, Crawford & Emmerson, 2009). Whilst this reality was acknowledged, it was widely assumed that these improvements could be made without major top-down reorganisations (Dixon & Ham, 2010; Timmins, 2012). It was therefore an unsettling shock to the majority of NHS professional workers when, in 2010, the Health Secretary Andrew Lansley introduced 'arguably the biggest restructuring it had seen in its' 63 year history' (Timmins, 2012; pg 7).

The new white paper 'Equity and Excellence: Liberating the NHS' (DOH, 2010) introduced dramatic structural reforms, abolishing existing Primary Care Trusts and Regional Health Authorities, and disseminating budgetary and commissioning control to local GPs. In addition, it was announced that over 20,000 managerial posts would be removed, a number which in fact proved to be much higher, alongside savings of up to £20 billion by 2014. These dramatic reforms subsequently enhanced the importance of effective resource and change management through leadership. Distributed, shared leadership was portrayed as even more of a panacea than in during previous reform movements, with responsibilities for innovation and change being advocated at all levels 'from the ward to the board' (The Kings Fund, 2012; pg iv).

As mentioned previously, increasingly hybridised clinical roles had been advocated as crucial for the effective development of the NHS and the effective uptake on innovations within organisations (Darzi, 2008; Appleby, Crawford & Emmerson, 2009; Ferlie et al, 2005). However, the majority of healthcare professionals reacted badly to these new reforms, which were seen as too extreme for the financial and social climate (Dixon & Ham, 2010). The British Medical Association, numerous professional colleges, and the Royal College of Nursing all opposed the bill, and complained that they were not being consulted about these dramatic changes or their proposed implementations (Timmins, 2012).

Despite this professional opposition, the bill was passed and, over the course of data collection in this study, dramatic reforms were taking place in the NHS. The disharmonious relationship between the politicians, managers and professionals subsequently increased the importance of professional hybrid leadership and management roles, which have frequently been advocated as key in integrating professionals with managerial or political leaders. Positions such as Clinical Directors are assumed to hold more influence over other clinicians than general managers, as they combine their professional values and ethics with the achievement of management initiatives (Currie et al., 2009b; Ferlie & Geraghty, 2005; Sehested, 2002).

However, how professionals are able to align their managerial roles and demands with their professional identity and ideologies is unclear, particularly among nurses who have always held less organisational influence than doctors. Whilst there has been little consideration of this challenge in existing policies, there has been an acknowledgement of the need for increased leadership development amongst professionals, in order to increase their leadership capacity. I will discuss leadership development within the NHS after a consideration of the organisational barriers to clinical leadership.

4.5   Potential Barriers to Leadership

Thus far, I have outlined the organisational history of the NHS from its' inception to the current organisational structure; from professionalism, to managerialism, and finally towards leaderism (O'Reilly & Reed, 2011). However, each new organisational discourse has not replaced the last, rather they are layered on top of each other, resulting in distinct tensions and conflicts. Whilst leadership is now seen as key to the modernisation of the NHS, the managerialism discourse is still prevalent, resulting in inherent problems for professionals attempting to enact leadership in this context. I now consider the organisational conflicts intrinsic to the NHS, and discuss the potential impact they may have on distributed, professional leadership and identity construction.

The importance of networks in encouraging distributed, emergent leadership is increasingly advocated as crucial for organisational change (Darzi, 2008; NLC, 2010). However, despite their potential to encourage distributed leadership, networks are strongly influenced by the continuing existence of hierarchies and markets. The bureaucratic nature of the NHS has historically been seen as a fundamental problem, and the removal of a hierarchical bureaucracy to allow innovation through networks has been frequently advocated (Blair, 1999; Frederickson, 1996; Meier & Hill, 2005). Paradoxically, in an attempt to challenge the bureaucratic nature of public services, central and hierarchical control has been reinforced (Hoggett, 1996; Meier & Hill, 2005).

The need for the NHS to have flexibility and to be freed from tight central control is advocated in multiple government White Papers (Darzi, 2008; DOH, 1996, 1997, 2000, 2009a). In reality, political control is more prevalent in the health service than ever, despite constant reassurances of more autonomy. One of the latest 'decentralisation' moves suggested a system of earned autonomy, whereby NHS Trusts which consistently obtained performance standards would be given more freedom to run their own organisations (DOH, 2000, 2009b). These proposals have been met with much scepticism, due to previous promises of reforms to increase freedom and flexibility (Goddard & Mannion, 2006). Even more recently, the creation of clinical commissioning groups, aimed at providing responsive health care purchasing for communities by doctors, have been met with similar concerns (DOH, 2011a; Mannion, 2011). In fact, central control remains tight, limiting managerial ability and maintaining the ability of politicians to influence the running of the health service (Blackler, 2006; Goddard & Mannion, 2006; Pollock, 2005). Organisational reform in the NHS is still driven by top-down enforcement from managers and senior politicians who generate policies, expecting public sector workers at the bottom of the hierarchy to enact them (Dawson & Dargie, 2002).

The high levels of accountability which are placed upon professionals due to this tight central control, and a continuing need to conform to strict performance measures, can be similarly detrimental to leadership (Hughes, 2003). The control of public workers is enacted through the old mechanisms of rules, regulations, monitoring rewards and penalties, all in the context of continually changing, ambiguous and contradictory goals passed down the hierarchy from political leaders (Brodkin, 2007; PIU, 2001). Professional, local leaders in the public sector are therefore seen as relatively insignificant, as they are dependent on the culture created by political leaders and organisational forces beyond their control (Currie, Humphreys, Ucbasaran, & McManus, 2008; Currie & Lockett, 2007; Van Wart, 2003). In fact, public sector leaders may not be leading at all, as they are unable to exercise innovation and change, and are merely implementing political policies. These problems were identified by the Performance and Innovation Unit (PIU, 2001) who advocated the need for policy makers to consider the impacts of legislation on encouraging or inhibiting public sector leadership, emphasising the importance of collaboration between managerial and political leaders.

Political leadership is critical in creating a climate of innovation and empowering public workers to make changes and implement the modernisation reforms, but this reliance on politicians to create this culture has resulted in a cynical view of government reforms being superficial and cyclical, due to the constant changing or revoking of previous policies by new ministers (Ferlie, Hartley, & Martin, 2003; Hartley & Allison, 2000; Trottier, Van Wart, & Wang, 2008). This excessive central monitoring allows central control, whilst at the same time insulating the government from front line responsibility. When public services fail, the government are quick to allocate blame to those 'accountable' at a local level, despite the fact that it is often contextual barriers imposed by the government which may have caused problems in the first place (Dawson & Dargie, 2002; Flynn, 2004; PIU, 2001). The accountability of formal leaders to conform and ensure organisations achieve these targets can inhibit the empowerment of informal leadership, thereby preventing distributed or collaborative leadership (Maddock, 2002; Martin, Currie, & Finn, 2009). This accountability of formal leaders to achieve government set performance targets means that distributed leadership is limited in favour of individualistic leadership, which does

not encourage innovation or risk-taking, and is at odds with the distributed, team based collective leadership advocated in policies (Bolden et al., 2006; Currie et al., 2005; Currie et al., 2009b).

Professional leaders are subsequently discouraged from taking innovative risks, due to the blame culture and external influences on them to achieve government targets (Javidan & Waldman, 2003; Kakabadse et al., 2003; PIU, 2001). The extent to which professionals are able to enact any leadership at all is debateable, as they are not attempting to act in a transformational way or suggest new visions, only acting to carry out the change initiated by policy makers (Currie & Lockett, 2007). Public service leaders are unable to lead effectively, as the organisational climate is not conducive to innovation or controlled risk, despite being advocated in policy (Borins, 2000; PIU, 2001). Distributed, emergent leadership is therefore unable to be effectively enacted, as it relies entirely on political leaders relinquishing tight control and allowing innovation and change to occur at all levels, a barrier identified as preventing distributed leadership amongst teachers in UK schools (Currie et al., 2009a).

Nursing leadership will also be inhibited by this reluctance to allow informal leaders to innovate, and true clinical leadership at all levels will be stifled by bureaucratic obstacles and a lack of formal authority (Kan & Parry, 2004). Whilst distributed, collective leadership is discussed and advocated in policies, the individualistic practice of leadership within the NHS continues to perpetuate more traditional models of leadership. For nurses, this is particularly challenging as they are not seen as traditional leaders, and will face further difficulties in attempting to align their professional identity with expected leadership behaviours. Can leadership development programmes mediate these difficulties, offering an arena for identity transition and construction as discussed in the previous chapter?

4.6 The Need for Leadership Development

Effective leadership development in the health service has been heralded as 'the missing link in the NHS reform story' (NLC, 2010a; pg 2). To promote the need for leadership within the NHS, and foster systems of leadership development, the NHS Leadership Council (NLC) was established, with a vision of developing excellent leadership at all levels of the system to enhance patient care (Dawson, Garside, Hudson, & Bicknell, 2004). The need for clinicians to be actively involved with leading and changing organisations is one of the key targets of the NLC, which sets out to infuse the NHS with a culture which places the responsibility for leadership amongst all clinicians (NLC, 2010b). In conjunction with this, a number of leadership development programmes have been established to develop leadership at various levels of the NHS, many with a particular focus on enhancing nursing leadership. Nurses make up the largest profession in the NHS (NHS, 2012) and are therefore crucial in the implementation of distributed leadership at all levels of the health service, ensuring that individual patient needs are being addressed at local levels. These leadership development programmes are run by multiple stakeholders, from national and regional NHS schemes (NHS, 2010d) to programmes run by the Royal College of Nursing (RCN, 2009), and many which are run with local NHS organisations.

The preoccupation with measurable, quantifiable outcomes in the public sector, resulting from the previous managerialism reforms, is reflected in reports from the Leadership Council which have a very results-oriented attitude towards leadership, and advocate the need for measurement standards and benchmarking frameworks to ensure leadership is delivering significant organisational improvements (NLC, 2010b). One of the benchmarks for measuring leadership is the NHS Leadership Qualities Framework (LQF), outlined in Table 3, which is advocated for use in the assessment of leadership skills and as the central component of many leadership development programmes (Inst. For Innovation & Improvement, 2005).

Table 3: Leadership Qualities Framework (Institute for Innovation and Improvement, 2005)	
Personal Qualities	Self Belief Self Awareness Self Management Drive for Improvement Personal Integrity
Setting Direction	Broad Scanning Intellectual Flexibility Seizing the Future Political Astuteness Drive for Results
Delivering the Service	Leading People Through Change Holding to Account Empowering Others Effective and Strategic Influencing Collaborative Working

The LQF is defended as a crucial benchmarking tool to improve leadership capability through a coherent framework (NLC, 2010b). However, it has been criticised by some as promoting a very traditional, individualistic view of leadership, emphasising the personal characteristics of leadership without considering the contextual complexity associated with emergent leadership (Bolden, Wood, & Gosling, 2006). The competencies described as 'self belief' or 'seizing the future' seem rather generic, and are more of a description of what is expected of NHS leaders, rather than a prescription of how to exercise leadership (Bolden & Gosling, 2006). Bolden, Wood et al (2006) voice concerns that the framework encourages professionals to redefine their role within corporate language, legitimising it rather than improving their leadership capabilities. They go as far as claiming that the use of the LQF will erode any chance of shared, distributed leadership if it is used as a benchmarking system. In addition, the LQF does not address *how* these leadership outcomes will be achieved, neglecting the intrinsic, and complex, issues associated with professional identities and leadership enactment.

Recently developed to work alongside the LQF is the Clinical Leadership Competency Framework (NHS Leadership Academy, 2011), which is said to offer a *'common and consistent approach to professional development, based on their shared values and beliefs, nested within professional domain standards and not organisational structures'.* Patient care is touted as central to the framework, thereby reducing any conflict between leadership demands and professional values. However, whether this framework is substantially different from the LQF is debateable. The tool remains fairly generic, with no consideration or acknowledgement of the potential struggles faced when adapting a professional identity. Additionally, it is worth noting that there is a separate medical leadership competency framework (Inst. For Innovation and Improvement, 2010) specifically aimed at doctors. All other healthcare professionals, including nurses, are categorised into the same professional domain, highlighting the continuing assumption that doctors are more legitimate leaders than nurses (McKenna, Keeney, & Bradley, 2004).

None of the existing leadership frameworks on offer in the NHS take into consideration the impact of identity, continually placing nurses at an organisational and cultural disadvantage due to their professional identity and the historic organisational culture, which does not facilitate nursing leadership. This is also reflected in an educational framework developed by the Department of Health to develop the leadership of the workforce, which focuses primarily on technical skills and the development of appropriate behaviours rather than supporting identity transitions (DH, 2012). Once again, this policy focuses primarily on the importance of medical leadership with only a fleeting mention of nursing leadership, which is portrayed as something which can be developed through skills training.

In the previous chapter, I outlined the importance of conceptualising leadership development as a space for identity change and construction (Carroll & Levy, 2010). However, this relies on organisational support for individuals to be able to fuse conflicting identities together. One of the widely held criticisms of NHS leadership development programmes is the negative influence of the organisational culture, which does not allow potential leaders the space to construct these identities or successfully fulfil leadership roles (Hewison & Griffiths, 2004). In addition,

leadership development within the context of professional tribalism is seen as particularly difficult. For example, one paper acknowledged a reluctance to even allow nurses to attend leadership development programmes, due to stereotypical assumptions about their professional identity (McAlearney, 2006). It is also continually advocated the leadership development programmes should bring together leaders from different professions and organisations (Kings Fund, 2012 – together we can), which neglects totally the nuanced differences or conflicts each profession may enounter when constructing identities.

Therefore, the leadership development programmes currently on offer within the NHS could be criticised as functioning primarily as methods of organisation control, attempts to get professional to conform to organisational priorities and desired behaviours (Alvesson & Willmott, 2002). They do not appear to directly address issues of identity. Subsequently, how helpful leadership development programmes in this context will be at facilitating identity conflict resolution, transition and construction is unclear.

4.7 Rhetoric or reality?

In this chapter I have outlined a clear rhetorical shift concerning the requirements for organisational reform. There has been a move from the social status and authority of administrators to managers, and now from managers to leaders, in the quest for public sector efficiency and excellence. Whether or not this change in emphasis was anything more than a rhetorical shift is debatable, as the inherent problems of the NHS such as tight central bureaucracy, the undermining of professional autonomy but strong informal professional influence, and the importance of measurable outcomes, remain prevalent in modern reforms. The similarity between the three organisational states is outlined in Table 4. The increasing organisational complexity can be seen in the increasing number of stakeholders, and there appears to be a significant difference in organisational structure between public administration as a monolithic bureaucracy, to post-NPM which combines competitive markets, bureaucracy

and networks. However, the differences between NPM and post-NPM, are not as clear-cut, and may only concern a rhetorical shift from managers to leaders.

The assertion of NPM in the 1980s that administrators were part of the bureaucratic problem and needed to be removed, led to the institution of managers who were portrayed as positive, innovative change agents (Learmonth, 2005). The extent of the difference between managers and administrators is debatable, as many styles of management, organisation and political control of the public sector remained the same, merely repackaged under a different name (Broadbent & Laughlin, 2002; Christensen, 2001) 'Administrator' became synonymous with the problems of the public sector whilst 'managers' were seen as the key to successful reforms (Griffiths, 1983). Descriptions of the functions of the two roles do not illuminate any particular differences. Katz (1955) suggested that a good administrator needed to adapt their skills to the situation at hand, and that an administrator should work cooperatively with their team, leading to create an environment of participation and collaboration. Descriptions of managerial functions echo the need to create conditions which can empower individuals to be entrepreneurial and innovative (Grey, 1999). Fundamentally, the main development in the managerial role appears to be an increased focus on the need for cost improvement (Griffiths, 1983).

As discontent once again begins to surface with the short comings of the public sector, the blame has shifted to the poor quality and standards of 'managers' with the only way to achieve sustainable, effective change and modernisation through the development of 'leaders' (Currie & Lockett, 2007; Lawler, 2008; NLC, 2010b). Leadership investment and development has now become a priority for public services on a global scale, advocated as the critical component to improve managerial and organisational performance (OECD, 2001). Is this a rhetorical shift to increase social status of 'leaders' as it did with managers in the 1980s? By relabeling activities as 'leadership' individuals are instilled with a greater sense of legitimacy and importance, thereby making them more likely to conform to political aims and feel greater commitment to their organisation, even if their actions and the boundaries to achieving effective change remain the

same (Learmonth, 2005). Is the rhetoric of leadership merely normative, to ensure continuing adherence to central control by ensuring professionals are on-board with governmental reforms?

Whether these reforms are new, or in fact a natural evolution of modernisation attempts packaged into different rhetoric, is a point of contentious debate. Many of the objectives of the NHS Leadership Council, such as the need to move from organisation centric services to patient centred services, away from rising costs and inefficiencies towards cost effectiveness and innovation, and a need to engage the public (NLC, 2010b)., are reminiscent of the NPM reforms of the 1990s. This can be seen in Table 4, where the only difference between the outcomes of NPM and post-NPM is the need for innovation rather than competition. Some believe these changes to be an on-going development of old theoretical reforms, phrased with different language, condemned as the latest 'management fashion' (Abrahamson, 1996; Frederickson, 1996, 2005; Gruening, 2001; Lynn, 1998).

However, this condemnation may actually be oversimplifying the matter, as there do appear to have been tangible changes in public sector organisations, regardless of the rhetorical shift. Economic theories and competitive markets are prevalent in the public sector, and the role of government in society and its accountability to citizens has become more accessible (Christensen, 2001; Hughes, 2003). It would appear that the 'old' culture of public services has mutated into different rhetorical concepts, combining traditional values and models with the newly important concepts of leadership. This overlap of traditional and new values and rhetoric has led to the tensions discussed above, tensions which may remain inherent in the public sector as managerialism is now fully embedded in the language of the public sector, and the rhetorical devices used are taken for granted (Ferlie & Fitzgerald, 2002; O'Reilly & Reed, 2011 Pollitt, 1993).

Table 4: Comparison of Reforms			
	Public Administration	**New Public Management**	**Post New Public Management**
Main Stakeholders	Clinicians Administrators Central Government	Central Government Devolved Government Departments Managers Public	Central Government Devolved Government Departments Leaders Public Managers Clinicians
In Charge	Professionals Administrators	Politicians Managers (enforcing policy)	Politicians Leaders (innovating within policy boundaries)
Organisational Approach	Bureaucratic	Fragmented central bureaucracy Devolved Responsibility	Fragmented central bureaucracy Devolved Responsibility Distributed Power
Aims/Objectives	Monopolistic service provision Budget Driven	Efficiency Competition Accountability	Efficiency Innovation Accountability
Rhetorical Focus?	Professionalism	Managerialism	Leaderism
Structure of organisation	Centralised bureaucratic hierarchy	Semi-decentralised bureaucratic hierarchy Competitive markets	Semi-decentralised bureaucratic hierarchy Competitive markets Devolved networks
Tensions Arising	Dissatisfaction with bureaucracy Inefficiency of spending Disillusion with quality of service Lack of consumer involvement Pressure to act like private sector Too much professional control	Tight political control Performance measures not necessarily appropriate Lack of professional involvement	Merely a rhetorical shift Tight political control Professional resistance to change

4.8   Conclusion

Public services in the UK have undergone dramatic organisational changes over the last 30 years, none more so than the NHS. A move from professionalism to managerialism saw the introduction of managerial control, competitive markets and measurable performance outcomes in the NHS, and the business culture and language of those reforms appear to have infiltrated the whole service. The overlap of the traditional values and structure of the health service, with the modern models of management based on private organisations, has resulted in a number of tensions and paradoxical reforms, many of which remain unresolved.

The need to involve professionals more fully in organisational decisions and processes, in order to achieve organisational change and encourage modernisation, has resulted in a move towards leaderism (O'Reilly & Reed, 2010; 2011). Professional leadership, with clinicians and managers working together is seen as fundamental to the success of the service, and there has been a concerted effort to ensure that this is not merely a rhetorical shift in focus, but one which has tangible effects within the NHS (Dawson et al., 2004; NLC, 2010b). However, professionals attempting to enact leadership and construct legitimate leadership identities in the NHS will face a multitude of structural obstacles, in particular the strong hierarchical and central control which continues to enforce performance measures. Excessively tight political control, and the obstructive nature of professional tribes within the organisation, have previously been problematic for managers attempting to exert autonomy, and will remain a problem as the rhetoric of the reforms move from an emphasis on management to leadership.

Strong accountability and the existence of the 'blame culture' of the health service will influence the ability of clinicians and managers to successfully innovate and make changes. Whether or not effective distributed leadership is possible in the health sector is contestable, and studies investigating the extent of distributed leadership in other public organisations found it limited due to a lack of empowerment and excessive political accountability (Currie et al., 2009b).

Whether clinicians in the NHS will be empowered to make front line changes remains to be seen, but what is clear is that individuals need support in constructing salient leadership identities at all hierarchical levels. Whilst government policies advocate the need for distributed, collective leadership amongst all clinicians, the proposed leadership frameworks such as the LQF (Inst. For Innovation and Improvement, 2005) convey a more traditional approach. These frameworks do not address issues of identity development or consider challenges to identity construction, and could be seen as mechanisms of organisational control, rather than facilitators for identity transition. As such, their influence on potential leaders' identity developments remains to be seen.

Whilst all professionals within the health service will arguably struggle to align their professional identities with constantly changing managerial demands, nurses are particularly vulnerable. As previously identified in other chapters, nurses are required to construct a professional identity which reflects an altruistic, passive ideal (Dingwall, Rafferty, & Webster, 1993; Goodrick & Reay, 2010). Due to their position within the organisational system of the NHS, nurses have not historically been seen as traditional leaders, and will face problems when attempting to construct leadeship identities, which are incongruent with their professional identities. Current leadership development programmes on offer within the NHS do not satisfactorily consider the intrinsic problems nurses may face in terms of identity construction, instead focussing on task or skills-oriented outcomes which are more suited to the medical profession (Bolden & Gosling, 2006; McKenna, Keeney, & Bradley, 2004). Whether, and how, nurses will be able to construct a legitimate leadership identity through interaction with others, within such a complex organisational context, remains unclear. This question is the focus of this thesis.

5 Methodology

5.1 Introduction

In the previous chapters I have examined popular theories of leadership, identified the importance of the potential impact of social identity on leadership identity construction, and outlined the organisational context of leadership in the NHS. From a review of the literature, I identified a research gap surrounding the interaction between identity and leadership. Using nursing as an illuminating case, I aim to explore the impact of a professional identity, which is orthogonal with implicit leadership schemas, on the construction of a salient leadership identity within subordinate groups. More specifically the three aspects of the study research question are:

- What identity conflicts do subordinate professionals encounter when attempting to lead?
- How are these identity conflicts resolved?
- What are the resulting identity constructions?

In this chapter I outline the methodology used to address these questions. To identify and recruit study participants, two leadership development programmes were used as recruitment sites, generating a cross-section of 32 study respondents across different hierarchical positions within the same organisation. 120 hours of participant observation was combined with these 32 longitudinal in-depth interviews, to gain an insight into the experiences of clinicians attending the programmes, focussing on the organisational and professional issues inhibiting or enhancing their leadership identities. 28 of the respondents were interviewed twice, generating over 60 hours of interview data, which was thematically coded to develop the theoretical understanding of the interaction between professional identity and leadership.

5.2   Examining Leadership and Identity

As discussed in the literature review, the concept of 'leadership' is diverse, abstract and poorly defined (Bass, 1990a; Kent et al., 2001; Yukl, 1989). Whilst leadership has historically been considered as an individual phenomenon, more recent studies have conceptualised it as a group process influenced by a number of endogenous and exogenous factors (Barker, 2001; Burns, 1978; Yukl, 2006). Historically prolific quantitative methods of data collection, such as the Multi-Factor Leadership Questionnaire (MLQ) (Antonakis, Avolio, & Sivasubramaniam, 2003; Avolio et al., 1999; Avolio, Sivasubramaniam, Murry, Jung, & Garger, 2003) have been discredited for ignoring this collective, contextual approach to leadership in favour of a reliance on the traditional individualistic theories (Kellerman, 2004; Yukl, 2006). These studies were de-contextualised, single level investigations, and were condemned for failing to consider the dynamic social process facilitating leader emergence (Conger, 1998; Guba & Lincoln, 1994; Schriesheim & Cogliser, 2009).

If leadership is a social, dynamic process which cannot be isolated and observed, it will alter according to time, social context and personal perceptions (Alvesson & Sveningsson, 2003a; Avery, 2004; Kort, 2008; Osborn et al., 2002). Developing this assumption, leadership could be conceptualised as a discursive, socially produced phenomenon (Kelly, 2008). In this circumstance, an individual understanding of leadership will depend upon personal perceptions, experiences and situations, leading to a dynamic, contextually based phenomenon (Fairholm, 2004). Individuals construct their own implicit leadership theories, based on their own expectations and perceptions, as well as common elements of leadership theory and the context in which leadership is enacted (Bresnen, 1995; Lord & Hall, 2003). The majority of leadership theories attempt to define leadership as a linear, individual process and do not take into consideration the organisational context which both affects, and is affected by, leadership (Marion & Uhl-Bien, 2001; Porter & McLaughlin, 2006). This can lead to simplistic and distorted conclusions, which do not consider the multi-level impact of leadership (Heracleous & Hendry, 2000; Johns, 2006). As mentioned previously, perceptions will differ amongst individuals and context, as well as being influenced by situational dynamics (Fry & Kriger, 2009; Lord et al.,

2001a). A temporal context must therefore also be considered as meanings may develop and change over time (Tierney, 1996).

Identity can also be conceptualised as a socially constructed phenomenon, the interpretations of which are subjective and responsive to context. Identity cannot be seen as a stable, isolated entity, it must be defined and constructed through interactions with others, through discursive mechanisms and narratives in an ongoing process of self-reflection, adaption and construction, shaped by social interaction (Goffman, 1959; Lindgren & Wahlin, 2001; Wells, 2007; Schwalbe & Mason, 1996). This process is influenced by social structures, such as organisations, which act as discursive spaces in which identities are constructed to enable individuals to make sense of their collective group identifications and roles (Brown, 2006; Ibarra & Barbulescu, 2010). If identity construction is considered as an interaction between social actors (Goffman, 1959), it can offer insights and understandings into the legitimating identity work individuals use to construct a desired identity outcome (Creed et al, 2002).

These assumptions require a philosophical approach which recognises the existence of socially constructed systems, and the influence of social context on events. One approach that allows this, social constructionism, is based on the assumption that the social world is shaped through human interaction and discourse (Berger & Luckman, 1984). From this philosophical position, everything is influenced by context and history, and would not exist without social interaction (Gergen, 1985). Organisations are perceived as sets of collective action, where individuals attempt to construct meaningful identities through narratives (Czarniawska-Jorges, 2010). Whilst identity cannot be fully interpreted through a social constructionism agenda, due to an inability to account for events beyond our understanding or perception (Cerulo, 1997), it can be used as an insight into organisational phenomena when the reciprocal influence of social structures and individuals and audience on each other are acknowledged (Czarniawska –Jorges, 2010; Lindgren & Wahlin, 2001; Stryker & Burke, 2000). Whilst I do not discount the possibility of a reality beyond our understanding or perception, for the purposes of this thesis I am primarily concerned with interpreting the subjective accounts of socially constructed identity

perceptions. In this way, I aim to offer an insight into the complex and dynamic process of identity construction within a social system (Stryker & Burke, 2000).

I use this understanding of leadership and identity as socially constructed phenomena to guide this thesis and shape the research design. There will be no attempt to 'discover' one universal understanding or truth, a positivist quest which has been condemned by some academics as detrimental to understanding the contextual variables of leadership and identity (Alvesson & Sveningsson, 2003b; Kelly, 2008). Instead, I focus on identifying the organisational, professional and social elements which shape interaction with others and influence the construction of a salient leadership identity. When investigating this phenomenon a research approach and method is needed which will allow participants to articulate their own constructions of leadership and identity, to capture rich data.

5.3   A Qualitative Approach

When researching leadership and identity construction, it is essential to take into consideration a number of contextual factors and individual perceptions. Qualitative research is more sensitive to the contextual significance of events because, unlike quantitative methods, the researcher is not attempting to impose standardised frameworks or conditions, but is instead attempting to explore the way in which the respondent perceives and constructs leadership (Bresnen, 1995; Bryman, 1984). Studies have demonstrated the discrepancies between leadership theory based on quantitative research, and the reality of applying these theories to organisational settings, where professional, organisational and cultural barriers are prevalent (Currie et al., 2005; Currie et al., 2009b). Kan & Parry (2004) demonstrate this clearly in their study using triangulation of qualitative interviews with the quantitative MLQ instrument. Although nursing leaders in this study were identified as being effective according to their quantitative assessment, use of interviews and non-participant observation found a number of organisational barriers preventing nurses from leading effectively, something that would not have been demonstrated with a quantitative approach alone.

Qualitative research consists of a number of interpretive methods which are situated in the real world, and focuses on rich descriptions of social phenomenon, whilst considering the contextual variables, making it more conducive to theory building than quantitative research (Denzin & Lincoln, 2003; Goodwin & Horowitz, 2002; Parry, 1998). In his paper of the same title, Conger (1998) extols qualitative research as *'the cornerstone methodology for understanding leadership'* due to the dynamic and symbolic complexities of the phenomena. Bryman, Stephens, & Campo (1996) suggest there are 4 types of qualitative research design: single case studies; multiple case studies; large amounts of semi-structured interviews with leaders; or inviting people to describe specific leaders or practices. When selecting a research method, it is essential to consider the context of the research and not to place too much emphasis on formal leaders (Bryman, 2004).

Reviewing the research questions in light of the issues discussed above, a research method was needed which allowed participants to articulate their own constructions of leadership and identity, and assess the way in which the process of identity construction was enacted within a number of levels of contextual analysis. I concluded the most appropriate method was a multiple case study approach, combining in-depth interviews and observation in a way that is sensitive to context (Bryman, 1999; Van Wart, 2003). In this way, respondents would be able to express subjective accounts of the social interactions they engaged in to construct identities and attempt to resolve conflicts.

5.3.1 Case Studies

Case study research involves a multi-level approach to the understanding of in-depth, dynamic settings, and is suited to research areas involving the development of existing theory or the building of new theories (Eisenhardt, 1989; Siggelkow, 2007). Building case studies around exploratory research questions can lead to focused and rich data which, using a combination of methods, can be expanded to develop novel theories (Curtis, Gesler, Smith, & Washburn, 2000; Eisenhardt, 1989; King, Keohane, & Verba, 1994). Cases can expand knowledge of individual,

group, organisational and social phenomenon by allowing researchers to examine real life events in a rich, holistic context (Yin, 2003).

Case studies can be used to develop theory inductively, as relationships and patterns among concepts within cases emerge (Eisenhardt & Graebner, 2007). As the outcome of this study is aimed at developing theory rather than testing it, a purposeful, theoretical approach to sampling is acceptable, and case studies should be selected for their ability to develop constructs (Eisenhardt & Graebner, 2007). Case study research does not attempt to select statistically representative samples, instead focusing on events or programmes which provide a unique conceptual insight into a theoretical framework at different levels of analysis (Curtis et al., 2000; Siggelkow, 2007; Yin, 2003). Interviewing participants from different hierarchical levels and organisational positions provides different perspectives on phenomenon, an essential element of multiple case research (Eisenhardt & Graebner, 2007; Gobo, 2007).

Due to the nature of case study samples it is possible to make analytical generalisations but not statistical ones (Curtis et al., 2000). To maximise the applicability of these generalisations, multiple sources of evidence should be used to generate rich examples of pattern matching and theoretical logic (Yin, 2003). The data collected can be generated from a wide variety of sources, but the methods most widely acknowledged as central to case study research are participant observation and in-depth interviews. The case studies in this study were purposefully selected for the insights they offered into leadership identity constructions at different contextual and organisational levels. Two case studies of leadership development aimed at clinical staff at different hierarchical levels within the NHS were selected for this purpose. These cases were not compare with each other, rather they were selected to give access to a stratification of respondents throughout the organisational hierarcy. Before introducing the case studies, I now offer a brief overview of the nursing professional hierarchy, to help contextualise the stratification of the subjects recruited.

The nursing hierarchy is structured according to a 'banding' system (scaled 1 to 8), with each band corresponding with a nationalised pay scale (DOH, 2004). All ward-based nurses enter the scale at pay band 5 after their professional training. The banding system corresponds with levels of seniority and responsibilities. Band 5 nurses are usually in ward-based, traditional patient care roles with little or no managerial elements. Band 6 nurses are slightly more senior in the nursing hierarchy, often combining their clinical work with small amounts of managerial responsibilities, usually in senior staff nurse or junior ward manager roles. Band 7 corresponds with Ward Managers, individuals who spend the majority of their time overseeing the day-to-day management of the ward. Whilst these individuals are nurses, and will retain some degree of clinical input, the majority of the work is managerial. At Band 8, posts are either very specialised clinical roles (which are fairly rare), or increasingly managerial roles such as department managers or modern matrons. At this level it is unusual for individuals to have any regular clinical contact. Above Band 8, individuals can take on more executive, board-level positions, which are not governed by the nationalised pay scales (DOH, 2004). This study recruited respondents from Bands 5 to 8, as well as some individuals in executive level posts, gaining a representation of the nursing profession across the hierarchical spectrum.

Case 1 – Invest to Lead

Case 1 was a leadership development programme run by an NHS Trust in the Midlands. The 'Invest to Lead' ran between September 2009 and February 2010, offering leadership development opportunities for 280 clinical and non-clinical staff across the organisation. The objective of the programme was to *'give some space for our current and emerging leaders to take stock and understand the organisation and its environment much better'* (Trust, 2010); pg 4). The overall aim was to disseminate knowledge of organisational aims, visions and priorities throughout all levels of the trust, encouraging leadership emergence throughout the organisation.

Staff members either self-nominated their applications or were nominated by line managers for the opportunity. Clinical staff ranged between hierarchical bands 6-8. In addition, a number of service users and board level directors were in attendance. A total of 5 sessions were held, focusing on the national strategic context of the health service, with a particular focus on national Government policy and the organisational leadership strategy. The sessions followed the outline of the QIPP agenda (Quality, Innovation, Productivity and Prevention), a government led initiative aimed at supporting NHS staff to increase quality and productivity and decrease costs, ultimately concerned with making efficiency savings (DOH, 2010). The QIPP agenda is advocated as a key component of leadership development across the NHS (NHS Leadership Academy, 2011). Sessions were grounded in a local, organisational and political context, aimed at grounding the work individuals were doing in the context of the Trust and the national agenda. At the end of the course a 'graduation ceremony' took place at which delegates received certificates and badges. Further opportunities for delegate development were offered in the form of bursaries and funding for conferences, and participants were also asked to complete action plans for their own leadership development over the next year.

Case 2 – Leadership at the Point of Service

Case 2 was 'Leadership at the Point of Service' (LATPOS), also run within the same NHS Trust in the Midlands. The programme consists of 10 optional modules: leadership and management in todays NHS; understanding and developing yourself as a leader; leading teams and developing others; understanding finances and using resources effectively; running and improving services; working in partnership with others; leading projects successfully; presenting information and communicating effectively; self and service development next steps; and marketing. These modules were 'opt in' and ran continuously throughout the year. Data collection for this case study occurred between October 2009 and September 2010. Clinical staff, from bands 5-7, were eligible to attend any of the modules they found appropriate. The approach of the modules was primarily to distribute and build leadership capacity throughout the organisation, by providing clinical staff with basic managerial and team leadership skills. This leadership development programme focused on developing capacity by improving the skills required for formal

management roles and situations. Although a small number of the sessions were related to leadership development, the majority were concerned with the logistics of managing and running services.

Despite the focus of the programme on building specific skills and managerial knowledge, the emphasis was still on learning and development to build leadership capacity. The programme was a space where clinicians could begin to adopt new skills which were removed from their traditional, professional role, moving towards behaviours associated with management or leadership. The programme therefore offered nurses the chance to build up non-clinical skills, such as project management, encouraging and supporting a move away from their prototypical professional identity and role.

5.3.2   A Cohort Approach

The two cases in this thesis are not being considered separately and compared, rather the subjects from both are being treated as a cohort. They were selected due to the access they offered to respondents from a stratification of the nursing hierarchy. Whilst both cases took a slightly different approach to leadership development, both programmes were concerned with distributing leadership throughout the organisation by building and developing capacity at all hierarchical levels. Case 1 took a more strategic overview of leadership aims and visions, and Case 2 attempted to develop specific skills required by leaders such as budgeting and project management. Despite this, the aim of both programmes was to distribute leadership by developing staff at different hierarchical levels and from a spectrum of professional backgrounds, a strategy advocated as an important avenue for new leadership development programmes (Ensley et al., 2006),

This study is not concerned with the effectiveness or perceived success of these programmes. Instead, I conceptualise the experience of leadership development as an arena which forces individuals to consider, and perhaps develop or change, their own leadership identity. This

approach has been advocated in other studies, which conceptualise leadership development programmes as a space for identity work and construction (Carroll & Levy, 2010; Lord & Hall, 2005). Both programmes offered this space, and as such a cohort approach can be taken, allowing results from interviews from the two programmes to be coded within the same data set, similar to previous studies (Pratt, Rockmann, & Kaufmann, 2006).

The benefit of using these two case studies is the opportunity to gain different perspectives on phenomenon by interviewing participants from different hierarchical and organisational positions (Eisenhardt & Graebner, 2007; Gobo, 2007). One of the benefits of using two case studies in this thesis was to provide perspectives from different hierarchical levels. Case 1 was aimed at staff members from across the trust, with clinical participants ranging from 6 to 8 and above (executive director levels), offering a broad spectrum of clinicians in different settings. Case 2 offered courses to front line clinicians, ranging from bands 5 to 7, working primarily in clinical and front line environments. Combining the results of both cases into a cohort study allowed an insight into the unique challenges or facilitators of constructing leadership identities at different hierarchical levels and in different service contexts.

These new identities will take time to develop and therefore changes in leadership behaviour are often not seen until 8-12 months after the programme has concluded, at which point the knowledge has been consolidated and used within individual roles (Hirst et al., 2004). To account for the temporal effect of these programmes on leadership identities and behaviours, the cases were followed from the beginning of the programmes until one year after conclusion, forming a longitudinal model of data collection.

5.3.3   Interviews

The majority of qualitative research into leadership uses in-depth interviews as the primary method of data collection. In a review of qualitative research into leadership, Bryman (2004) compiled a table of 72 studies. 62 of these used semi or unstructured interviews as their primary

method of data collection. Interviewing seems to be the method of choice for many researchers investigating leadership, particularly in the public sector (Bryman et al., 1996; Van Wart, 2003). Although this lack of methodological diversity has been criticised, with calls for a greater incorporation of ethnography and grounded theory (Bryman, 2004; Conger, 1998; Parry, 1998), it seems apparent that for a dynamic social process such as leadership, which is individually subjective, it will be particularly difficult to observe or measure.

The most appropriate and popular qualitative approach remains a combination of in-depth interviews and observation in a way that is sensitive to context, allowing between-method triangulation and an understanding of the context in which interviews are conducted (Bryman, 1999; Conger, 1998; Van Wart, 2003). It is essential for researchers to understand how the respondent views the world, without researcher preconceptions being imposed upon them. In-depth interviews allow this, and generate rich data with minimal researcher reactivity (Bryman, 1984; Parry, 1998). Individual interviews allow an insight into how large scale transformations are experienced and affected by the interactions of individuals, and focus on how these interactions are embedded in the social and cultural context (Gerson & Horowitz, 2002). Unstructured interviews offer a much richer account of the interviewees' experiences, knowledge, ideas, and impressions. They are less constrained by the researchers pre-understanding, and there is space for the negotiation of meanings so some level of mutual understanding is reached (Alvesson, 1996)

In addition, studies using interviews to gather data have illuminated a number of areas which quantitative studies could not. A number of studies by Alvesson & Sveningsson (Alvesson & Sveningsson, 2003a, b, c) illuminated the discursive power of leadership, demonstrating that mundane managerial acts were seen as special when described as 'leadership'. They also demonstrated that what respondents say about leadership might be different from how they enact it, reducing the efficacy of direct observation techniques. This discursive nature of leadership is diverse, and relies upon qualitative research to illuminate the manner in which socially constructed language can influence organisational language (Kelly, 2008)

Despite this reliance, it is important to recognise and address the limitations of the interviewing technique. It is assumed that respondents will perceive the meaning of questions in the same way as the interviewer. If this is false, and the respondent perceives the social world from an unpredicted perspective, they may not be answering the same questions (Mason, 2002). In a similar fashion, respondents only answer questions which they are asked, relying on the researcher correctly identifying and asking questions which are important and inclusive of each aspect of a phenomena (Waldman et al., 1998). Assumptions are also made about the nature of interview responses. It is suggested that, when interviewed, leaders will respond in a manner which reflects their abilities in a positive, successful light (Murphy & Ensher, 2008). It is therefore not always clear whether the responses are describing an accurate report of events, a report of what they think happened, or merely stating what they want others to believe (Goodwin & Horowitz, 2002).

Furthermore, relying upon respondent language to describe a concept can be problematic. Respondents will be limited in their descriptions of abstract constructs, as there are some elements of social experience which cannot be effectively expressed within the confines of a language (Mason, 2002). When examining leadership in institutional settings, there is also the danger that respondents will seek to provide locally acceptable answers and respond using the ideological and generalised language of the institution (Alvesson, 1996; Dingwall, 1997; Smith, 2002). This provides results which are not useful to researchers, as they lack descriptive content and do not give an insight into what the respondent actually thinks. Researchers also suggest that a large degree of variability will exist in interviewee accounts of leadership, and contradictory stances will be common as they attempt to describe a discursively extraordinary event, which is often relatively mundane in practice (El-Sawad, Arnold, & Cohen, 2004; Fairhurst, 2009). The existence of multiple social identities is also played out within interview settings as professional, organisational, personal and social identities interact and are accessed at different times, to generate different trains of thought and opinions (El-Sawad et al., 2004).

It is equally important to recognise that interviews are socially constructed environments of interaction, which do not directly reflect the nature of the reality being discussed (Dingwall, 1997; Rapley, 2007). The meaning emerging within the interview is constructed through interaction with the interviewer and the participant, and the researcher therefore needs to be reflexive and aware of issues of social identity such as race, class, gender and profession which may impact the interaction and relationship generated (Seidman, 1998). The interview setting acts to create negotiated, contextual responses, which can provide an understanding of the meaning interviewees gave to experiences, rather than a direct account of the event, and can be a response to the interview situation rather than the experience being related (Alvesson, 1996; Fontana & Frey, 2003; Seidman, 1998). Mason (2002) suggests that interviews are best used as a site of knowledge construction between interviewer and respondent, to generate a shared view of a concept, something which will be more rigorous when identifying the context of the respondent's answers. It is therefore suggested that the questions should be specific and rooted in a theoretical base, ensuring that responses to not become abstract and discursive (Gerson & Horowitz, 2002; Mason, 2002). There is a need for longitudinal interviews as people's understanding and perceptions of leadership will change over time (Fairholm, 2004).

Taking into consideration the limits and benefits of interviews when investigating leadership, a semi-structured interview protocol was developed based upon the themes arising from the literature review. I was aware of the need to be adaptive and flexible when picking up on themes suggested by the interviewee and responsive to their views of leadership and experiences of identity construction, rather than imposing my own views. Based upon these considerations an interview lasting between 45 minutes and 1 hour was developed. As scholars increasingly begin to appreciate the roles of dynamic processes, rich longitudinal research is needed to provide the details of how these processes actually play out, particularly with the case of Distributed Leadership (Heck & Hallinger, 2010). Therefore, a second interview was conducted after approximately one year, discussing any impact emerging from the leadership programme over time, and searching for any contextual changes affecting their potential leadership ability.

As is the nature of semi-structured interviews, it was expected that the interviews would vary between each respondent as I responded to themes developing from the conversation. However, the main topics or guiding questions are demonstrated in Table 5.

Table 5 – Interview Themes

- What is your definition of 'leadership'/general discussion about leadership?

- Any examples of good leadership/leaders?

- How is leadership enacted in clinical practice?

- Why did you decide to attend the leadership course?

- Has the leadership development programme changed the way you approach leadership?

- Do you identify yourself as a leader?

- How will you enact leadership in your clinical work?

- What causes you conflict when attempting to lead?

- How do you overcome the conflicts you encounter?

- The potential for distributed leadership in the NHS?

5.3.4   Participant Observation

In order to address some of the issues involving the validity and contextualisation of interview data, the involvement of participant observation in the study can reduce the problem of interview variation. It provides a multi-layered and dynamic view of context, exploring how individual, group, organisational and socio-historical influences reflexively interrelate at particular moments in time (Dingwall, 1997; Fairhurst, 2009). Participant observation allows researchers to develop some understanding of the culture they are studying, and observe and interpret interactions between actors (Delamont, 2007; Marshall & Rossman, 1999). Whilst it does not necessarily involve actively participating in events, it relies on researchers interacting with actors as they are observing them, generating a rounded, in-depth account of the group which can be used to contextualise interview responses (Bryman, 1988; Delamont, 2007).

Due to the subjective nature of participant observations, and the potential impact of the researcher observing the group, reflexivity is one of the most important aspects of the fieldwork process (Delamont, 2007; Seale & Silverman, 1997). Whether or not participant observation can truly provide an insight into others' perceptions of culture is questionable. As Bryman (1998) points out, there are 3 components comprising the representation of different cultures: the way in which the native views the world, the ethnographer's interpretation of how they view the world, and the ethnographers construction of their interpretation of the natives view of the world for their intellectual and cultural community (Bryman, 1988).

Due to the sensitive nature of clinicians' work in the NHS, and the inability to directly observe leadership in action, it was not appropriate for me to observe clinicians attempting to 'lead' in practice. Instead, I attended all sessions of the leadership development programmes, to gain an insight into the experiences of the participants, and to contextualise the information generated from interviews. The insights gathered from participant observation were not primarily used to shape the results set out later in this thesis, rather they were used to identify the pertinent issues at play and shape interview questions accordingly. Additionally, attending the programmes over a period of time allowed me to begin to develop a relationship with some of the respondents, increasing the potential that they would agree to be interviewed. Access to the programmes was negotiated with the host NHS organisations. Following participant observation guidance (Delamont, 2007) I attended sessions and documented detailed field notes to develop a rich contextual understanding of the experience of the courses. Field notes were kept and notes discerned between observed events and observer inference (Gibbs, 2007). This amounted to approximately 120 hours participant observation. This data was not primarily used to contribute to the study results, as it would have been difficult for me to 'observe' the social interactions which form the identity construction process. Instead, the participant observation work was used to frame the context of data collection, ensuring that I developed a collegiate relationship with many of the programme participants. In addition, my experience of the programmes

enabled me to contextualise the arena of their identity transitions under discussion in interviews, giving a richer understanding of the events and social situations being described.

5.4   Ethical Considerations

Research within the NHS must follow rigid ethical guidelines to protect staff and patients. The study was designed and sent for ethical approval following guidance from the National Research Ethics Committee and the Medical Research Council (MRC, 2005; NRES, 2010). Ethical consideration was given to the five areas identified by the Royal College of Nursing (RCN) as integral to NHS research studies (RCN, 2009).

1.   **Informed consent**

The (RCN, 2006) classify informed consent as the agreement to participate in a study after risks and alternatives have been offered to an individual. To ensure informed consent in this study, participant information sheets were sent out with invitations to participate, allowing potential respondents to consider the research at their leisure before responding. Contact details were also available on this sheet. After expressing an interest in participating in the study, the researcher and respondent met to further discuss the research and any questions arising, at which point a consent form was signed if the participant wished to continue. Contact details were also left with participants at the end of the interview in the event of any questions or concerns arising.

2.   **Confidentiality**

Confidentiality of respondents was a key consideration, as NHS Trust members were less likely to respond honestly if they were concerned about their employers having access to their responses. To ensure confidentiality, only the researcher had access to the recorded interview sessions or transcripts. All identifying information was removed from transcripts before study

publication, to ensure individuals could not be identified, and each respondent was assigned an anonymous code to protect their identities.

3. Data Protection

Coded interview transcripts and participant information was stored on password-protected computers, accessible only by the researcher. Signed consent forms were stored in locked drawers and will be destroyed after 7 years in accordance with university guidelines.

4. Right to Withdraw

All participants were reassured before the study that their decision to participate was purely voluntary, and they could withdraw from the study at any point and without explanation. Due to the longitudinal nature of the study, respondents were informed that if they wished to withdraw after the first interview, before the second, the data gathered from the first interview would still be used in the study.

5. Potential Benefits and Harms

Due to the non-invasive, theoretical nature of the study, the direct benefits and harms to participants were limited or non-existent. Benefits were outlined as the development of leadership theory and potential beneficial application to their profession and their NHS organisation. No potential harm was identified.

Participant information sheets, consent form template and study protocol can be found in the Appendix at the end of the thesis. Ethical approval for the study was received from Nottinghamshire Research Ethics Committee 2, as well as local NHS Trust Research & Development departments.

5.5   Validity, Rigour and Reflexivity

The aim of any research study is to produce findings which are rigorous and valid. However, what is classified as legitimate research is a narrow and distinctly positivist approach (Bryman, 1984; Torrance, 2008). Whilst quantitative methods are concerned with discovering reliable and representative results, qualitative research is more concerned with generating an in-depth understanding of a small number of people's experiences of an abstract phenomena (Seale & Silverman, 1997). Qualitative research is often criticised for not producing rigorous or valid results, due to the prominent positivist desire to impose scientific certainty onto complex social circumstances (Torrance, 2008). Indeed, one of the reasons for the proliferation of scaling questionnaires in social science research is the ability to objectify and statistically analyse results (Bryman, 1984). Whether qualitative and quantitative research can, or should, be held accountable to the same standards of rigour and validity is debateable.

There are now a multitude of methodological positions with a broad range of important factors which are not acknowledged by the criteria of validity and reliability (Seale, 1999). This problem of diversity is also exacerbated by the lack of a unified theory or method related to qualitative research, making it impossible to provide a consensus on criteria for valid, rigorous research (Rolfe, 2006; Torrance, 2008). Rolfe (2006) goes on to argue that qualitative researchers should reject the positivist assumption that rigorous research will uncover universal 'truths' and in doing so should reject the preconceived ideas about rigour and validity. This contentious view is rejected by Porter (2007) who argues that whilst the definition of 'valid' research will change with different methodologies, it is essential for the production of quality research that research findings are rigorous. By Porter's definition, rigorous research is the ability to take into account a multiple of different perspectives on the same phenomena, whilst accepting the limitations of any of these perspectives.

Therefore, the quest for rigour continues. It is argued that better qualitative results can be achieved by triangulating them with quantitative methods, providing multiple perspectives of the

concept under investigation (Seale, 1999). It is also suggested that multiple researchers should be used for transcript analysis due to different individual perceptions (Seale & Silverman, 1997). As this approach is not possible for this PhD thesis, the use of transparent coding with the assistance of qualitative computer software was used, as advocated by Seale and Silverman (1997).

Malterud (2001) suggests a set of criteria which could be used to assess qualitative research, highlighting the importance of researcher reflexivity and acknowledgement of bias and subjectivity. Researcher reflexivity is crucial as the researcher is part of a socially constructed world themselves and therefore cannot remain entirely neutral to what is being studied (Alvesson, 1996). It is crucial to be aware of interpretive acts and self critical of one's own assumptions and to consider fundamental questions about the ability of the researcher to capture the complex, emerging nature of the social experience (Cunliffe, 2003). The ability to incorporate a wide range of perspectives on one phenomenon to gain an increased understanding of its complexities is also advocated. The main criteria by which research should be judged is the generalisability of the research method and findings, reliant upon sampling in the study and appreciation of the context. This is a common area of criticism for qualitative research as it is not easily reproduced due to differences in researcher perspectives and the inability for semi-structured interviews to produce standardised respondent questioning (Mays & Pope, 1995; Parry, 1998).

Despite the problems identified, it is not impossible for qualitative results to produce generalisable results. A clear understanding of the context and a multi-level contextual analysis is required to facilitate this (Williams, 2002). It is also important to ensure systematic and logical research design, collection and interpretation is recorded to allow replication in another setting (Mays & Pope, 1995). However, despite this emphasis there is no way, nor need, for research to be entirely replicable, as it is not possible to account for the complex possibilities inherent in social situations (Porter, 2007). Although a criticism usually withheld for qualitative studies, this is also true in quantitative work as it is unusual that every variable has been accounted for (Mays

& Pope, 1995). The important issues influencing the transferability of results are the representativeness of the sample and the nature of the context (Mays & Pope, 1995). This study takes a multiple case study approach, offering insights into different organisational areas and at stratified hierarchical levels, allowing thorough exploration of the leadership phenomenon. Although the results will only be applicable to these specific settings, it is hoped that the diverse range of data collected will allow generalisations with nursing, the NHS, and within the theories of distributed leadership and identity. Generalisations will also be applicable to other traditionally subordinate professions, such as para-legal staff (Abbott, 1988), and also within more traditional professions (such as medicine and law) with regards to their potential identity conflicts.

To ensure rigour and validity in this study, the protocol was explicitly set out to allow transparency and some replication of the approach. A framework from the Cabinet Office offers advice about producing valid and reliable qualitative research, suggesting that data collection and analysis need to be transparent and rigorous and fundamentally related back to theory (Spencer, Ritchie, Lewis, & Dillon, 2003). This framework was followed in protocol development. Field notes were kept, discerning between observed events and observer inference, as it is important to differentiate between recording observations of what actually happened and the researcher's own inferences or opinions about interactions (Gibbs, 2007). Interviews were audio taped and transcribed. Data coding was facilitated with the use of a computer analysis programme NVivo, as discussed below.

The issue of researcher reflexivity has been discussed as one of the primary issues for qualitative researchers. Ahern (1999) identifies the use of 'bracketing' as an important tool for demonstrating the validity of data collection and analysis. Consisting of the ability to identify and put aside personal feelings in a reflexive and iterative fashion, researchers should identify potential areas of subjectivity or role conflict, and consider and address feelings which indicate a lack of neutrality (Ahern, 1999). Reflexive bracketing is particularly important in this study, as I have previously worked as a nurse, and therefore have my own perceptions and experiences of

leadership in the NHS and within the profession. To address these preconceptions and my existing professional identity, critical reflection and identification of researcher bias was an on-going process. The input of academic supervisors also helped me to guide and triangulate the research analysis, and prevent bias analysis.

5.6 Empirical Analysis

19 respondents were recruited from Case 1, and 13 from Case 2, totalling 32 interview subjects. The breakdown of these respondents according to hierarchical band and gender is outlined in Table 6.

Table 6 – Demographic breakdown of respondents

BAND	Female	Male	No. Overall
6	7	2	9
7	13	2	15
8	3	2	5
EXEC	1	2	3
	24	**8**	**32**

As well as representing a broad spectrum of hierarchical positions, the respondents also fulfilled roles with varying clinical and managerial responsibilities. Of the 32 nurses recruited to the study: 9 individuals held traditional nursing roles associated with close patient contact, clinical care, and little or no managerial responsibilities. 20 respondents were classified as 'middle managers' (Currie, 1999), fulfilling roles requiring a mix of clinical and managerial work along a spectrum from primarily clinical with management responsibilities (such as ward mangers), to primarily managerial with limited clinical contact time (such as directorate managers). 3 respondents were recruited from board level, executive posts.

One year after the first interview, study participants were approached again for a second, follow-up interview. 28 of the 32 respondents agreed to be interviewed again. This amounted to over 60 hours of interview data. This was combined with the field notes collected from 120 hours of participant observation of the leadership development programmes.

Data collection in this study occurred at the individual level, which can be problematic when attempting to apply analysis to group level events. To rectify this problem, if data is collected from a broad range of individuals who can be said to represent the group as a whole, individual level analysis can be used to draw inferences at group level (Klein, Dansereau, & Hall, 1994). When combined with participant observation, a consideration of the wider external context can allow rich and in-depth analysis at multiple levels (Chun et al., 2009; Hofstede, Harris Bond, & Luk, 1993). Due to the nature of professional socialisation, and the strong salient identity which exists among nurses, individual responses to interviews can be seen as representative of collective group values and ideals (Klein et al, 1994). It is important to discern between contextual or role influences which may alter the salience or prototypicality of professional identity, something which is possible as interview respondents were recruited from multiple hierarchical levels. As such, it was possible to determine if nurses at Band 5 level held different opinions and values from nurses at Band 8. Whilst all respondents were seen as representing the wider professional group, the diversity of responses from different hierarchical levels offered a richer understanding of in-group processes and influences on leadership identities.

5.6.1   Coding

Alasliutari (1995) suggests that qualitative analysis consists of *'unriddling'* the phenomenon being studied, by combining the observations and data acquired, to suggest a theoretical interpretive explanation of the events examined. Johnson (1998) recommends analytic induction, whereby a number of purposefully selected cases are intensively examined by researchers who reflect upon their experience of the phenomenon and formulate explanations. Template analysis allows the thematic coding of data to generate contributions to theory. Coded material is then

organised in a hierarchical manner to provide general, parallel and sub-category codes to allow analysis at different levels of specificity. This allows a flexible and adaptive approach to research analysis, as codes and themes are not predetermined but are induced from preliminary analysis of the data (Gibbs, 2007; King, 1998). Identifying key themes and patterns creates categories to link the data with theoretical explanations (Coffey & Atkinson, 1996).

In this study, three areas of thematic coding were applied: areas of identity conflict; conflict resolution; and resulting identity constructions. The themes generated from the interview data were combined with observational field notes and tertiary evidence from the organisation, to enhance accuracy and contextualise the interview responses (Silverman, 2003). This coding process was facilitated through the use of the software programme NVivo, which can produce a more rigorous and transparent approach to data analysis (Bringer, Johnston, & Brackenrisge, 2004). Whilst the computer can assist in coding and data management, it does not analyse data, and it is the researcher who must interpret, conceptualise, examine relationships and develop theory; preventing data become de-contextualised and quantified (Bligh, Kohles, & Meindl, 2004; Bringer et al., 2004).

Table 7 outlines the data coding structure which was followed during empirical analysis. Areas of identity conflict were identified first, using deductive interpretation following on from the conclusions of the literature review. Three potential origins of conflict were found, as shown in Table 7, and quotes from interview transcripts or field notes used to validate assumptions. Conformity to a problematic prototype was the first area of conflict, displayed through behaviours which did not encourage leadership identities or a move away from prototypical roles. Emergence from the prototypical group was the next source of conflict, identified by a perceived reduction in group support and influence, and a concern about a loss of their salient identity. Finally, the organisational context of the identity transition was a source of conflict. Two elements were identified within this code: the influence of a dynamic political environment, and the meditating impact of formal and informal professional hierarchies.

After identifying these areas of identity conflict, interview transcripts were inductively coded for responses relating to conflict resolution. In doing so, I identified three types of resolution processes. Respondents in conflict initially worked to 'aggrandise' their current identity, whether that be as a prototypical group member or as a non-prototypical member with an adapted identity. This was shown through statements which elevated their identity to a higher moral plane through self-enhancement. To further enhance the importance of their identities, respondents then used 'demonising' work, shown through attempts to undermine others who did not share their salient identity. This was displayed towards prototypical and non-prototypical nurses, both through interview responses and through behaviours I observed during the leadership development programmes, and recorded in field notes. Finally, I identified that most respondents constructed salience hierarchies, evidenced through statements relating to the 'splitting' or 'fusing' of conflicting identity elements.

Following the inductive coding for identity resolutions, I looked for evidence relating to the creation of resulting identity constructs. I identified four different resulting outcomes: clinician, manager, split hybrids and fused hybrids. Table 7 outlines the type of evidence used from interview data to determine identity types. Clinicians where characterised by their rejection of managerial or formal leadership identities, whilst managers advocated the importance of management whilst actively distancing themselves from their professional background. Split hybrids were identified due to their high levels of identity conflict, and attempts to resolve this conflict through compartmentalising, or splitting, their identities. Fused hybrids afforded both aspects of their identities, professional and managerial leadership, with the same levels of salience. The specific nature of each of these identities is discussed in detail in later chapters.

Table 7: Data Coding Structure			
Overall Theme	**Thematic Codes**	**Second Order Codes**	**First Order Codes**
Identity Conflicts (coded deductively from literature review)	Problematic prototype	Not encouraging leadership behaviours	*'You're in a very vulnerable position as a leader of nursing and people never ever will be good enough because there will always be complaints' (Nurse 11)*
	Non-prototypical emergence	Loss of group influence and support	*'There are times when there is a considerable lack of support and sometimes it can be very hard, very distressing to lead' (Nurse 26)*
		Loss of salient identity	*I'd hate to think I'm not a nurse… I struggle with that sometimes' (Nurse 25)*
	Organisational barriers	Political context	*'I know that's quite an easy thing to say but it is, it's just, with all the changes that keep coming down from the department of health, you start changing and something else comes along and you start having to change it slightly differently and you never catch up' (Nurse 4)*
		Informal professional hierarchies	*Doctors tend to think they're above the nursing staff' (Nurse 8)*
Identity Resolutions (coded inductively from interviews and field notes)	Aggrandising	Elevating professional group membership to higher moral plane	*'It comes down to patient care being the most important thing and that overrides everything else' (Nurse 7)*
		Acknowledgement of importance of changing identities for new roles	*'I think my role has developed as the ward has developed… as a manager I'm able to make a bigger change for more people and I'm happy doing that and seeing the effects of that. I'm a manager as it stands now. That's developed over time' (Nurse 17)*
	Demonising	Undermining non-prototypical nurses	*'I think there are lots of really rubbish nurse leaders… it seems that some people can't wait to get out of clinical and they get into a management job and they're hopeless at it' (Nurse 9)*

			Field Notes: Observations of interactions between clinical and non clinical nurses at leadership development programmes and discussions about non-clinical nurses being out of touch and unrepresentative of nursing
		Undermining prototypical nurses	*'Nurses are up their own arse, they've got this thing about 'I'm special' – you're not special' (Nurse 24)* Field Notes: Observations of interactions between clinical and non clinical nurses at leadership development programmes
	Salience Hierarchy	Splitting conflicted identities	*'I'm very clear about the entire 37 ½ hours being a managerial role, not a clinical one. If there's an occasion where we're short-staffed I will be part of the shift but I'll do that as an agency nurse and not ward manager because I do think you need those two types to be separate' (Nurse 7)*
		Fusing all aspects of identities	*In most areas you end up with an overlap between my nursing leadership remit and my managerial, strategic leadership of the directorate' (Nurse 2)*
Identity Constructions (coded inductively from interviews and field notes)	Clinician	Rejection of managerial leadership identity	*'I wouldn't' want to be a stand-alone manager; I wouldn't want to be the manager here. I would refuse if I was asked' (Nurse 15)*
	Manager	Rejection of professional identity	*'I don't really like the word nurse, it doesn't carry enough respect… I don't think I'm a nurse' (Nurse 13)*
	Split Hybrid	Personifies different identity according to situation	*I use different job titles depending on who is in the room' (Nurse 31)*
	Fused Hybrid	Creates new fused identity, both identities are salient	*'I don't behave solely as a nurse because it's not my job to champion nursing needs. It's my job to champion the needs of all the workforce. When it's appropriate I take time to champion nurses because I'm passionate about nursing but my focus has to be on strategic leadership and governance' (Nurse 2)*

5.7 Conclusion

In this chapter I have outlined the methodological approach for the study and considered some of the key challenges to be faced. Conceptualising leadership and identity as phenomena which are constructed through interaction with others, I used a social constructionism perspective to guide this research project. Focussing on two case studies of leadership development programmes as an arena for identity transition and construction, semi-structured interviews and participant observation were used to generate rich and complex data sets, giving an insight into the way identity is constructed through narrative identity work. Considering the importance of temporal, organisational, professional and social context, and identity factors, I initially used template analysis and coding to determine first order codes, before inductively coding for theoretical explanations, basing this understanding within the context of the litereature review. The qualitative analysis programme NVivo was used to organise this data and facilitate coding. To ensure study rigour and validity, the research process was as transparent as possible, following the study protocol and using theoretical rationale for coding choices. Researcher reflexivity has also been identified as a fundamental aspect of the study and was considered throughout. Analysis of data collected at the individual level was used to infer about processes occurring at the group level, ensuring a multi-level approach considering different aspects of the leadership phenomenon. The results generated from these methods of data collection offer insights into the impact of professional identity on leadership identity construction, particularly in the context of subordinate professional groups.

6   Identity Conflicts

6.1   Introduction

This study is concerned with the identity conflicts encountered by subordinate professionals attempting to construct leadership identities, with a specific focus on nursing as an illuminating case. Three research questions were devised from a review of the literature: What are the identity conflicts encountered by subordinate professionals when they attempt to lead? How are these identity conflicts resolved? And what are the resulting identity constructions? The next three empirical chapters set out the study findings in response to each of these questions.

In this chapter I present the findings used to address the research question: What are the identity conflicts encountered by subordinate professionals when they attempt to lead? Throughout interviews it became clear that many respondents were in positions which could be considered as 'leadership' roles, but these roles were associated with high levels of identity conflict. The nurses interviewed struggled to identify themselves as leaders, often giving examples of others as 'heroic' individuals, but reluctant to label their own behaviours as such. Exploring the reasons behind this identity confusion, it appeared that nurse respondents at all hierarchical levels struggled to align the incongruence between their traditional, salient, professional identity, and their new managerial leadership roles. Episodes of identity conflict were often triggered by a transition from a traditional, clinical nursing role towards one with more managerial elements. This chapter explores the conflicts encountered during these transitions.

It is worth noting that, despite it being a longitudinal study, I have not discerned between the first and second interviews. This is because there were little or no differences evident between respondent's first and second interviews, as the conflicts they encountered and their attempts at legitimating identity work remained the same. The implications of this are discussed later in the thesis.

6.2   A Salient Professional Identity

The respondents in this study were taken from a range of hierarchical positions, from staff nurses and ward team leaders, to those in senior executive level roles. Whilst the nature of their jobs varied, all respondents shared the same professional background and all began their careers working in a clinical team of nurses. The socialisation processes associated with membership of a professional group engenders a strong sense of identity, and a distinct alliance with other members of the group. This was seen in interviews with assertions that nurses favoured leadership from others with a similar background:

> *I think that if, from a nurse's point of view, if you know that somebody who is managing*
>
> *you is a nurse by background themselves you automatically have that connection because*
>
> *you would expect them to know what you're going through (Nurse 8).*

This shared identity and understanding of *'the nurse ethic' (Nurse 17)* was seen as crucial for potential leaders to be accepted by groups of nurses. Those managed by non-clinical individuals were vocal in their disapproval and discussed episodes in which conflict had occurred as a result of their different backgrounds:

> *I had to stand my ground to let her know that even though she is my boss I'm a clinician*
>
> *and I don't see why I should have to be in line to somebody who is not a clinician (Nurse 1)*

A shared professional background was therefore seen as crucial for potential leaders, particularly at the traditional, clinical level. For leaders to emerge from the team at this stage they needed to demonstrate a prototypical group identity, embodying accepted behaviours and values. By being perceived as highly prototypical, these individuals were able to emerge as informal leaders, without being in a position of formal authority:

> *Before I was the service team leader I was one of the people that the majority of the team*
>
> *would come to when they had issues or things they were struggling to deal with… So*

although I wasn't a team leader at that point in time I was the person people would look

to (Nurse 17).

This respondent was able to emerge as a leader because of her membership within the team, and their identification of her as representing group behaviours and having excellent clinical skills, affording her a large degree of credibility and legitimacy when influencing team processes. Other respondents acknowledged the process of emergence by the most prototypical member of the team:

In some ways she fell into it because someone retired and she was the natural one to do

it, and I think that's the case with a lot of band 7 team leaders. People just step up

because they were the natural one who would sort things out and take the lead anyway

(Nurse 12)

For these individuals, it was their perceived prototypicality which facilitated their move into formal leadership positions. The support given to those individuals who were seen as influential within the group initially helped them in their new leadership role:

A sense of we're all in this together... we're all in the same place trying to do the same

thing. So when you're physically in the same place and you're wearing a uniform which

binds everybody in some way, people are joining in and coming along and it's quite easy

in terms of leadership (Nurse 13)

Informal, emergent leaders could therefore successfully begin to develop a leadership identity in this environment, facilitated by the psychological support stemming from their salient group identity:

You feel like you can take on the world because you know you've got their support

(Nurse 8).

Their prototypical, salient identity, developed through professional socialisation processes, framed their actions within a stable and legitimate sphere of influence. However, whilst this

conformity to prototype was seen as a crucial element in the development of a professional identity, and the ability to influence group processes, the nature of the prototype was problematic.

6.2.1   The Problematic Prototype

Whilst all respondents were clear about the strong sense of self they associated with their professional identity, the problematic elements of group behaviours were also noted:

> *It's very easy for cracks to start to happen and nurses are the worst for being envious and backbiting and that sort of thing. And so it is, you're in a very vulnerable position as a leader of nursing… I suppose I think nurses are often their own worst enemies and that makes me a bit sad (Nurse 4).*

Nursing behaviour was seen as self-inhibiting, often resulting in a lot of intra-group hostility. Conformity to prototype perpetuated the image of a subordinate profession, as individuals tended to lack confidence about their abilities, and were reluctant to highlight or acknowledge their leadership potential:

> *I think as a nurse sometimes you don't realise how good you are. And I think that's a cultural thing in nursing, sometimes you don't realise what we can do, what we do know…. it's around confidence, and I think the thing with nurses is we can lack confidence in our own ability (Nurse 3).*

This inhibiting culture of nursing was perpetuated through socialisation processes, which many felt were contributing to a lack of effective nursing leadership enactment. Student nurses were not seen as adequately prepared to take on modern leadership roles, which were different from the traditional nursing roles they were trained to expect:

> *When I talk with nursing students, I don't get the sense that they're aware of the bigger picture that's around. I don't get the sense that they understand about strategy. They*

come out of training and they're not actually that aware of in terms of preparation

(Nurse 3).

We show them the wrong reality when they're training, and the reality is not like that at

all (Nurse 13)

The socialisation process was therefore seen as perpetuating the subordinate culture of nursing. This resulted from a lack of confidence, displayed by their reluctance to take on leadership roles, or to identify themselves as leaders:

I do things to the best of my ability, but as for saying whether I'm a leader I would find

that quite hard. I think that's something that's easier to say about somebody else than

about yourself. I would aspire to be a good leader… but I wouldn't think that anybody

would necessarily say that (Nurse 29).

Whilst a socialised lack of confidence was on element of their reluctance to be identified as a leader, another was the perceived importance of playing down leadership success, in order to conform to group behaviours. During interviews, any sense of success or achievement was downplayed and reluctantly acknowledged, as it would be contradictory to the salient group culture to appear confident or overly successful:

I think there's a culture there, you don't want to look as if you've made it or anything… I

think nurses culturally are very self critical and self deprecating (Nurse 26).

This idea that *'you don't want to look as if you've made it'* was common in interview responses, and was particularly noticeable in discussions about other nurses who had overtly labelled themselves as 'leaders'. This self-identification was labelled 'egotistical' (Nurse 7) and seen as incongruent with traditional group behaviours, leading to a negative opinion of them from other group members. This process reduced the leadership capability of emergent leaders, and in turn the organisational leadership capacity of the entire professional group.

Despite the acknowledged problems associated with the group culture and prototype, respondents discussed ways in which it was perpetuated through recruitment mechanisms to

ensure group stability. Formal leaders acknowledged attempts to maintain the status quo of the group, by recruiting new members or identifying and nurturing existing members who conformed to team and leader stereotypes:

> *I'll be honest when we're doing the interviewing a lot of it is around will this person fit with the team. Because we can't afford to have somebody who wouldn't fit with the team (Nurse 16).*

Other respondents shared this sentiment, and the potential impact of this desire to maintain team culture and process was acknowledged:

> *What the NHS should be doing is actively looking for different thinkers, for people that do not think in the box… but what tends to happen is when we're interviewing people we tend to employ like minded people because we think they'll fit in, when in actual fact we should be employing the people that don't fit in to bring in the new ideas, rather than the clones* (Nurse 5).

This desire to maintain the status quo, to protect the team culture, has a negative effect on the identification and emergence of effective leaders, as recruitment strategies perpetuate non-leadership behaviours. This can be harmful for the profession, particularly as it can stifle change and innovation:

> *I have worked with managers who see that as a threat if members of the team are saying look we've been thinking about this, why are we doing this this way, wouldn't it be better… they're actually threatened by that (Nurse 23).*

Group members are discouraged from being ambitious or attempting to adopt leadership behaviours, and unusual behaviour resulted in negative relationships with other team members:

> *If you get somebody in a team who is very driven and wants to work their way up the other nurses think 'oh they just want to make a name for themselves' (Nurse 26).*

In turn, this prevents new ideas or behaviours, which may be misaligned with traditional behaviours:

Who is going to stick their head above the parapet and say 'oh, I'll give you this wonderful idea'...you've got to feel that you're going to be supported with it and not scapegoated (Nurse 5).

Ultimately, by protecting the group ideology, potential leaders are undermined. The need to conform to these prototypical behaviours is problematic in the development of individual leaders, as their salient identity is one which sees success or ambition as something to be downplayed. Modern day nurses all face a certain degree of internal conflict, as these stereotypical group behaviours are not representative of their increasingly managerial role within the modern NHS, leading to intragroup conflicts and an inability to promote their group leadership potential. Nurses who emerge as informal group leaders will often find themselves taking on more formal positions of management over time, forcing them to step away from traditional, prototypical behaviours and develop a new identity. This transition was a primary area of respondent identity conflict.

6.3   Identity in Transition

As discussed above, the stereotypical group culture associated with nursing is self-deprecating and averse to individuals identifying themselves as leaders. Whilst informal leaders can emerge from within the team by personifying these prototypical behaviours, the move to formal positions of leadership and management require individuals to act against expected group behaviours and take on roles which may be incongruent with their traditional professional identity. For many, this transition was particularly difficult to resolve, and they often questioned the legitimacy of their non-prototypical role:

When I first started stepping out of practice I felt so guilty at not providing direct care. It took me weeks to get over it. Because we were so desperately short of nursing staff how can anybody justify sitting in front of a computer, when there are people out there that are cold and frightened, how can you do it? I question whether we can even call ourselves clinicians actually (Nurse 13).

This loss of clinical identity was a major issue for respondents and seen as having a negative impact on the desire for other clinicians to move into these general management roles:

As you progress up the nursing ladder you tend to see less and less of the patient and I know that's why quite a lot of people won't go into management because they don't want to lose the face to face contact with the service user (Nurse 4).

In addition to questions of role legitimacy, a move away from the supportive, stable nature of their team environment caused issues of conflict for those who felt isolated in their new, unfamiliar roles:

A leader without followers and support will get nowhere… So it can be a little bit lonely at times, you're on your own and you have to fight for your own thing all the time… it can grind you down (Nurse 1).

The loss of that team support, coupled with the increased level of formal responsibility and managerial demands led multiple respondents to comment on this sentiment:

I have found ward manager to be a very lonely place at times. I have had the support but the reason I say I find it a lonely place at times is that at ward level I had somewhere else to go (Nurse 22).

The loss of the collegiality and support offered from being an accepted group member, with a strong influence on individual social identity, was exacerbated by feelings of being deskilled and unsupported in the move into formal leadership roles, with increased managerial responsibility:

Moving from nursing to managing staff, managing budgets, managing teams, managing services; my early memories were of feeling deskilled. I felt very confident and competent as a clinician and I felt a complete novice as a manager (Nurse 14).

The feeling of being deskilled and unprepared for the role was frequently discussed, and the difficulties of adopting managerial responsibilities, which their clinical roles had not prepared

them for, undermined their confidence in their leadership ability, adding to their internal conflict about moving out of a purely clinical role. One respondent who had recently moved into a ward manager role discussed the lack of preparation they received:

> *Somebody asked me what training you get as a ward manager and I said you don't, you don't get any. I turned up on a Monday morning and my name was on the door and I had an office and something like 78 emails saying attend this meeting, do that report, contact this person, this person. As soon as your name gets put to that area with ward manager, after it you're that person (Nurse 22).*

The majority of respondents in this study were in positions of middle management, balancing managerial demands with some elements of clinical work. This meant that individuals often encountered conflict as they attempted to combine two roles which were perceived by some as incompatible: one focused on prototypical nursing values, associated with patient care and clinical priorities, and the other on managerial processes, budgets and targets. The conflicts reported by these respondents often stemmed from situations in which their managerial role would have to take precedence over values or priorities associated with their professional identity:

> *People expect me to prioritise things that I would rather not. If I have a client booked in I need to prioritise that and I need to have consistent prioritisation of seeing clients but there are times when I have to rearrange them because my management responsibilities dictate that I do that, which is unfortunate (Nurse 2)*

These role conflicts are particularly demonstrated in discussions about the pressure to meet targets and achieve cost cutting measures. Most commonly discussed was the prevalence of targets and performance measures associated with clinical outcomes, which were not seen as representative of nursing roles. Nurses in positions of formal leadership faced a subsequent struggle to legitimise the nursing contribution through performance measures, widely viewed by clinicians as irrelevant and non-representative of the essence of nursing:

There's a lot of good care that you can't monitor (Nurse 11).

For leaders this resulted in a negative impact on their relationship with clinical staff, as well as an internal conflict between their accountability to their patients and the need to meet targets:

You're so busy trying to make sure that we don't breach and we don't miss out on any of the targets, you can forget the person that you're actually there for and the service that we're actually there to provide (Nurse 4).

For leaders trying to maintain both a professional and managerial identity, this incongruence between their dual role demands caused conflict with their team, and with their hierarchical managers, as they attempt to juggle multiple demands, with conflict primarily stemming from the salience of their nursing identity and values:

Because I'm a nurse manager for want of a better phrase, it's not about money for me and I tend to ignore those bits and just focus on patient care. That puts me in conflict with my managers who are very detached from the ward and very money focused (Nurse 6).

Nurses occupying dual positions reported a very uneasy balance between their managerial and clinical responsibilities, often leading to internal and external conflicts. A move into more managerial roles required them to take on demands and tasks, which may be at odds with their traditional professional identity, a large aspect of their social identity.

6.3.1   The Loss of Group Influence

Although some respondents were keen to maintain some degree of group influence by combining their managerial and clinical roles, the transition into a role incongruent with their traditional, professional behaviours often caused a change in perceptions about them from the rest of the group. Taking on formal positions of leadership elevated individuals above and out of the team, where team members perceived them as 'management', a term associated with negative connotations. Respondents in clinical roles often referred to individuals in management positions negatively, depicting them as individuals unable to cope with a professional, clinical role:

> *Too often people from clinical backgrounds are promoted to management positions*
> *perhaps because they feel uncomfortable with the clinical role and are ambitious people*
> *who want to move up the ladder (Nurse 12).*

Being ambitious and wanting to 'move up the ladder' are seen as negative characteristics which are incongruent with the prototypical expectations of the group. The negative perceptions of those in formal positions reduces their credibility and legitimacy as a member of the team, subsequently reducing their efficacy as they are no longer seen as a prototypical group member and *'the team might see you as management and treat you accordingly' (Nurse 15).* Formal team leaders are therefore no longer seen as members of the team and find their leadership potential reduced:

> *I still have close friends on the nursing side and they said people don't tell me anything*
> *now. So I'm not as in the know as I was (Nurse 18)*

> *Once I came out I had to look at things differently… your credibility isn't quite the same*
> *with the staff group if you're an outsider going in. The team in practice don't allow*
> *outsiders in and when I'm out of the group it's quite difficult to be a leader. (Nurse 13)*

Paradoxically, by attempting to take on more formal leadership positions, potential leaders find their credibility and effectiveness reduced, as they are no longer perceived as a full member of the team. Influence now comes from the formal authority they hold, rather than their informal power over others due to their prototypical identity. Nursing leaders subsequently face a struggle because they have lost the practical elements of their professional identity and adopted managerial roles, which are detached from direct clinical care. Whilst other nurses saw this behaviour as non-prototypical, resulting in a loss of nursing group membership, against the backdrop of the wider organisation they continued to be categorised according to their professional background of 'nurse'. This in turn caused conflicts, as the wider organisational hierarchies undermined their influence and leadership ability.

6.4   The Organisational Context

Over the course of longitudinal data collection, the national context of the NHS was undergoing a period of dynamic reforms, due to a change of central government and radical proposed NHS developments. Whilst the cynicism about the cyclical nature of NHS reforms and the conflict between managerial and clinical demands is well documented in research into the NHS, concerns about national policy in this study were exacerbated by the drastic reforms proposed by the new Conservative government, who were perceived by some as a threat to the NHS. Cost-cutting procedures were prevalent and for many nurses in management positions with no direct clinical responsibilities, their jobs were at risk, designated as non-essential staff, and their concerns were frequently voiced. As a result respondents who felt their jobs were threatened were reluctant to take risks or make changes:

> *At the moment I've got my head down, ears open, making sure I've got bums on seats at*
>
> *all the bases (Nurse 19).*

'Keeping their heads down' reduced the likelihood of nurse leaders emerging from clinical roles into managerial posts, which were seen as vulnerable. The importance of nursing leadership was undermined, as strategic leadership posts were cut and seen as unnecessary. Respondents noted the impact this had on the lack of a clear career structure for nurses aspiring to higher positions of formal leadership, and the lack of clear professional figureheads to aspire to:

> *A lot of higher-level posts are being removed to free up money and with that goes a lot of*
>
> *experience, knowledge and leadership. Whole swathes of people in all these different*
>
> *areas are vanishing fairly rapidly… a huge amount of skills go with them (Nurse 30).*

Career opportunities for nurses were subsequently limited, and their leadership contribution undermined, as they were seen as expendable middle managers:

> *It is getting more and more difficult for there being a clear career structure in nursing,*
>
> *because of cost pressure we're having to take away posts… you get to band 6 nurse and*

then there's nowhere to go to because when you step above that line there's very little

that's not going into a manager's role, but then there aren't many managers either so

there's very little career progression (Nurse 10)

Forcing nurses to move out of clinical practice into managerial roles, which are at risk and subsequently removed, means that nursing leadership is less visible, undermined and has a detrimental effect on the emergence of new professional leaders, who have no clear role models. For nurses already at this level, the continued undermining of their role and their ability to influence organisational processes was seen negatively, and they often reported a sense of disempowerment:

No matter how many meetings and 'what do you think' scenarios you had we were still

told it was going to happen. So you sort of lose any faith in actually being able to

influence anything (Nurse 12).

Respondents frequently reported a sense that they were unable to affect real change, or truly lead change in teams as, despite the rhetoric of national policy advocating the need and development of front line nursing leadership, the prevalence of centrally imposed target systems and reforms inhibited or prevented it:

I think they don't allow you to lead, you're not allowed to lead anymore (Nurse 13).

6.4.1   Informal Professional Hierarchies

Alongside the formal mechanisms, which can undermine the development of a successful leadership identity, the NHS is an organisation full of informal professional hierarchies and interlinking networks. These complex, informal professional hierarchies, prevalent in the NHS, coexist alongside formal management hierarchies, meaning that in some circumstances nurse leaders are required to influence different groups of professions. During interviews, the existence

of strong, professional groups and the maintenance of status hierarchies within the health service were acknowledged, and the traditional, powerful influence of doctors was frequently mentioned:

Even though it's a multi-disciplinary team, it's still very status oriented... it's hard to challenge a doctor really because they think they're above nursing staff (Nurse 9).

The assumption that doctors held more influence than nursing staff had an impact on the ability of nurses to emerge as leaders within multi-professional teams, or enact distributed leadership because:

 You had to fight hard to be listened to and take your point seriously (Nurse 7).

The outcome of this status differential was an undermining of nursing leadership, even at high hierarchical levels. Two respondents in this study held executive, board level roles, yet still reported a degree of resistance as a result of their professional background:

I think there's a dynamic in my part of the organisation that may be about me being a nurse... sometimes people say things to me and challenge me in a way that they would probably never say to a medic... certainly to a consultant medic they wouldn't address them in the same way (Nurse 2)

I do a lot of work with groups of medical staff and sometimes I wonder would they say that if they didn't know I was a nurse. If I was an accountant would they take a different tack? (Nurse 16)

Nurses seem to feel their legitimacy is undermined due to having to 'fight' to have a voice alongside the medical staff, in a system traditionally dominated by medical leadership. Even respondents at very senior levels who held clear strategic leadership roles reported feeling undermined at times, due to attitudes held about their professional backgrounds, resulting in them questioning whether other colleagues view them as legitimate leaders. The way in which these individuals address these issues, and create a credible leadership identity, is discussed in later chapters.

Whilst the traditional power of doctors within teams could be seen as negative influence on the development of nursing leadership, respondents were clear of their legitimate role within multi-disciplinary teams when doctors were not in a leadership position. Nurses were clear, and were supported in accounts of respondents from different professions, of the existence of an informal status hierarchy, which placed nurses as legitimate leaders above Allied Health Professionals (AHPs). These professionals were seen as being of equal or lesser status within teams working alongside nurses, but they were often not accepted as legitimate leaders of healthcare teams, roles reserved for doctors and nurses:

> It*'s 4 o clock in the morning and some drugged up 19 year old manic patient is threatening to punch your lights out and there's no cavalry coming, then if somebody's done that I'll listen to them, I'll respect them. Rather than an OT* (Occupational Therapist) *whose biggest crisis is somebody needs an emergency kitchen assessment. I don't like this generic leadership thing. I don't like anybody can be a manager (Nurse 15).*

This negative view towards Allied Health leaders of MDTs was discussed frequently. An Occupational Therapist in a position usually held by a nurse was interviewed as part of the study, and their responses reflected the difficulties they faced in establishing themselves as legitimate leaders within the traditional, professional structure of the NHS, dominated by doctors and nurses:

> *I've had polite surprise when I introduce myself and people ask me 'are you a nurse' and I say no I'm not, I'm an OT by background. And I've had sympathetic looks to say that must be really difficult for you. I think people don't really understand or appreciate what I can bring to the post because I'm not a nurse (Occupational Therapist).*

This individual reported difficulties in being accepted by the medical and nursing staff as they took on a role traditionally held by nurses. This non-prototypical behaviour on their part resulted in negative behaviours, at least initially, from nurses. This in turn undermined the professional leadership potential of Allied Health Professionals:

In the last 10 years we've had social workers and OTs in management positions, and it is always a bit of a worry that they don't know what it's like… often there isn't the understanding of each other's roles. My last job, our senior management was a social worker; she wasn't very popular and had some strange ways about her… There is a bit of a worry that someone is in charge who hasn't risen through the ranks (Nurse 11)

For clinical leadership within the health service, there remains a strong, clearly visible internal hierarchy of professions. These hierarchies have a clear impact on the development of nursing leadership identities, in both positive and negative ways. Struggling to develop a legitimate identity in an organisation built around medical dominance, nurses are often undermined or at least feel undermined in their leadership contributions. Even nurses in high hierarchical positions question their legitimacy in the eyes of doctors, and are often reminded of the traditional status hierarchies. However, these traditional hierarchies are not totally detrimental to nursing leaders. Nurses have historically led ward based multi-disciplinary teams, holding leadership positions over allied health professionals and voicing reluctance at the possibility of AHPs taking on traditional nursing positions of leadership. In this respect the informal professional hierarchy perpetuates the traditional position of nurses, paradoxically helpful and unhelpful in legitimising their leadership contributions in the wider organisation.

6.5   Conclusion

In this chapter I have outlined the results inferred from interview responses, exploring the areas of identity conflict encountered by nurses attempting to take on leadership positions. These identity conflicts primarily originate from role transitions, forcing nurses to move away from their salient, prototypical identities. All respondents in this study started from the same position, as a member of a clinical nursing team. To emerge and progress as leaders they initially needed to be socialised into a professional identity, which they then had to display to be accepted as a member of the team. This shared group identity allowed them to take on informal positions of leadership,

influencing others through shared values and ideals. When these nurses took on positions of formal leadership, they were no longer seen as prototypical of a group whose culture discourages ambition, elevating them out of the team. This move causes an internal conflict for individuals, as they need to resolve the incongruence between their professional nursing identity and their new managerial identity, which has pushed them outside of the team which once supported them. The roles of each identity are incompatible: the clinical values champion the needs of the patient, whilst the managerial values focus on the need to cut costs and achieve targets. Individuals will often struggle to successfully align these role components. This is compounded by an organisational system which undermines nursing leadership, due to perceptions about their clinical background, and informal professional hierarchies which strongly support the existence of medical leadership over nurses.

At all levels, nurses reported high levels of internal conflict stemming from a traditional professional identity, which is often incongruent with modern day nursing and managerial demands. Despite these conflicts, respondents gave clear descriptions of successful nursing leadership processes at all levels. How do nurses balance these identity conflicts and role demands which initially seem incongruent? The next chapter discusses the work employed by nurses to cope with the identity conflicts encountered during role transitions.

7 Conflict Resolution

7.1 Introduction

Following deductive analysis to identify areas of identity conflict, it became clear the problems encountered by respondents were inextricably linked with their prototypical, professional identity. Despite these conflicts, it was evident that nurses continued to move away from their traditional roles, taking on increasingly managerial positions within the organisational hierarchy. This chapter examines the research question: How are the identity conflicts resolved? Inductive coding of interview transcripts showed how respondents attempted to resolve the resulting internal conflicts, through three processes: aggrandising through self-enhancement; demonising through out-group comparisons; and developing salient hierarchies through splitting or fusing identities.

7.2 Aggrandising

As identified in the previous chapter, the majority of respondents reported some level of identity conflict, stemming from the uneasy balance between their managerial and clinical responsibilities, and the perceived incongruence between their professional identity and their potential 'leadership' identity. When exploring the way in which respondents began to rectify these conflicts, it became evident that their professional identity and nursing background were guiding them in their roles, helping to shape the creation of a new identity. The importance of a salient professional identity was aggrandised by all of the respondents, using language to elevate nursing to a higher moral plane. By highlighting the perceived importance of this, individuals were able to legitimise their roles as potential service leaders above those without this professional background and clinical experience. Nursing practice was described as '*above and beyond' (Nurse 10)* and nurses portrayed as sharing a sense of higher ethical purpose than those from outside the profession:

The NMC is to me a very powerful body in that I have a code of conduct I have to work to and I really do believe in that, so working with other nurses I believe they work to the same code of conduct. So like my manager, we both think very similarly about those sorts of things. I'm a very honest and ethical person and I don't believe in cutting corners… And I think part and parcel of that is around the nurse ethic (Nurse 17).

The 'nurse ethic' was seen as a crucial part of these respondents' identity, and their values were almost romanticised:

*I do very much have that kind of emotional connection with patient care… it's like having a child and then being able to connect… you feel something inside. I feel something inside about what I do; I feel something passionate about [*our specialist*] services (Nurse 13).*

I was trained to be the voice of the service user, to be the advocate; to be there for the service users when they need you, to listen to their needs and provide those needs for them (Nurse 1)

Constructing their professional identity in this elevated manner demonstrated the importance of their nursing background to their self-identity.

As previously identified, this salient identity can cause conflict for individuals who move out of nursing practice and away from teams and supportive groups. However, individuals in these formal managerial positions continued to aggrandise their clinical identities, using their professional background to construct their identity, despite their non-prototypical roles and behaviours:

Although I still would put down that I am a nurse if anybody asked me what profession I did, and I don't practice clinically and everything now, but I do think that my professional identity helps me continue to do what I do… getting something through from the NMC reminds me, oh god yes I am a nurse. That is why I'm here; this is why I did go into this job a long time ago… you need things like that just to remind you because you do get lost in all the chaos of the stuff that's coming through (Nurse 4).

By maintaining this salient identity respondents were able to use their nursing background as a way of legitimising their managerial roles, aggrandising the use of their professional values and elevated sense of ethical behaviour to guide decisions and focus their priorities:

> *I need to remember the reason why I'm here and that's to provide a service and not be trite about that… So I still regard myself as a nurse even though I don't have any clinical practice (Nurse 26).*

Many respondents reported relying on their professional background and the values associated with their nursing identity to guide their actions, helping to maintain patient care as a priority over bureaucratic process.

As such, respondents aggrandised their professional background as improving, rather than detracting from their managerial responsibilities, as they were able to act more ethically and altruistically than general managers without this background:

> *I think that's what makes me a good manager because I'm able to hold on to what's important. Or maybe it makes me a bad manager depending on what side of the fence you're looking at. For me it's about patient care, doing the best for the people I look after and giving them the best service which is more a nurse point of view than a management point of view. Management's about savings and cost cutting and getting the most for your money. Whilst I try to incorporate that into things I do and make sure it's a quality service and value for money it still comes down to patient care being the most important thing and that overrides everything else (Nurse 6).*

The shared identity, which many general managers did not possess, was seen as enhancing their legitimacy amongst staff:

> *I enjoy here a level of credibility because of my previous clinical role, that many previous general managers within this service have not enjoyed, and I think that's been very helpful to me (Nurse 3).*

Most respondents moving into managerial roles were aware of the legitimacy afforded to them when they were seen as part of the team, and were keen not to lose that element of their identity. These individuals continued to undertake prototypical roles alongside their managerial posts, enabling them to continue to aggrandise their professional values and behaviours, which were viewed as more fulfilling and rewarding than the managerial demands, construed as a mundane necessity for the functioning of the team:

I miss it that much that I put myself on the agency and do regular shifts so I can still have that clinical contact, because that's what I really enjoy and that's what keeps me going. You know, I'll do a managerial shift and I go home and my head will be spinning with all the stuff I've got to do, but I do a clinical shift and, I'm sat talking to patients and I'm doing lots of obs and all the stuff I used to do as a ward nurse, and I go home and I'm much happier when I go home after a clinical shift than I am a managerial shift (Nurse 6)

In addition to the job satisfaction and legitimisation of their own identity, visibly undertaking clinical care alongside their managerial work afforded respondents a degree of respect from their team as they were still seen as demonstrating prototypical nursing behaviour, acting in a manner congruent with the group expectations and roles:

I find a lot of solace in my clinical work. When things are getting on top of me I find the clinical work a welcome break... I am still part of the team. When people are pushed and resources aren't great I'm not beyond rolling up my sleeves and getting in there. Like I say I do enjoy it... I'd much rather be in the day room chatting to patients, being around the staff team rather than answering my phone in my room (Nurse 22).

Whilst all respondents were clear about the importance of their professional background, and the way it legitimised their actions, the way in which clinical and non-clinical nurses aggrandised their individual roles were different. As discussed in the previous chapter, due to the nature of the nursing hierarchy and culture, potential leaders are elevated out of the group and will eventually

move away from clinical work all together, causing internal identity conflict, external role conflicts and the reduction of their potential leadership legitimacy. Many respondents in non-clinical, managerial roles were unable to maintain a truly prototypical identity within their formal, managerial position, as they were unable to engage in the clinical teamwork discussed above. These individuals had to adapt their group membership, legitimising their adaptation through aggrandising work.

7.2.1 Adapted Group Membership

To overcome the negative associations with moving away from their salient in-group prototype, respondents in these managerial roles employed secondary aggrandising work through self-enhancement mechanisms, demonstrating an altered perception about the ideology and values associated with their professional identity. This was shown through a change in attitude about the role of nurses in the health service:

> But actually thinking that doing physical care is the be all and end all is not, and that was my narrow view. Once I came out I had to look at things differently and get different perspectives (Nurse 27).

The different perspective adopted was the assertion that managers with a nursing background were crucial for the progression of the clinical nursing workforce, as they were able to work in a more strategic manner and impact a wider range of services:

> I step into a clinical leadership role, a managerial leadership role and an organisational one, which puts me at a distinct advantage because I work in several layers of the organisation (Nurse 31).

These respondents are clearly developing an adapted professional identity, aggrandising the need for individuals with clinical experience and nursing values to move into management positions, thereby having a larger impact on the nursing profession. The potential of a strategic leadership

role was seen as greater than what could be achieved at ward level, and was aggrandised as a way to influence the entire nursing profession for the better:

> *I just think that actually the NHS needs really good, solid nursing leadership. Because actually nursing in the NHS is the cornerstone, it is who delivers most care and I think that quality is something that's not been the focus of any of my roles before, and it's something that I would find more fulfilling than I do now. A role that has the opportunity to improve the experience of services in a different way (Nurse 16)*

> *I want to be in an area where decisions are being made. I can use the experience I've got over the years to be part of the decision making rather than being on the outside all the time fighting for the change. I'd rather be part of the change for the benefit of wider community (Nurse 1)*

These non-prototypical respondents were therefore able to aggrandise their role through self-enhancement, which legitimised their contribution as improving the future of the nursing profession. By acting in non-stereotypical roles, they believed they were able to advocate group values and needs at higher strategic levels by maintaining their salient nursing identity in managerial roles. Those who did so found their ability to influence stronger professions increased as they moved away from prototypes:

> *I've found it quite interesting to think about, now I have a role where I manage clinical directors, psychiatrists, and actually having a background as a nurse that's quite an interesting juxtaposition in terms of hierarchy. So that's been quite a learning about the transition from being a nurse who's more subservient in that hierarchy into a position where I've skipped round them and gone above them (Nurse 16).*

A number of respondents in managerial positions often acknowledged the need for nurses to move away from prototypical behaviour to achieve more influence in the NHS. Aggrandising their own adapted identity, breaking away from prototype to achieve leadership influence, was subsequently legitimised:

I think people who want to go into leadership in nursing in particular they've got to get involved in things. Things won't come to you you've got to make it happen for yourself... And that's what we need to give nurses because I think a lot of the time we're very easy to drop behind. Oh, we'll just stand with this consultant or we'll let the psychologists do that bit because they're good at numbers and doing graphs and charts and things like that. Well, actually we're pretty good at that when we get our heads round it (Nurse 3).

Individuals used aggrandising work though self-enhancement to legitimise their identity and behaviours, to themselves and to others. By elevating their values and ideals to a higher moral plane, they were able to aggrandise their professional background as a crucial and legitimate aspect of their identity. However, prototypical behaviour could only be maintained by those in traditional, clinical roles. During transition to more managerial roles which did not support prototypical behaviours, respondents had to adapt their group membership to achieve legitimacy, and behave in socially expected ways according to their role. This adaptation created two divisions amongst the respondents: prototypical nurses and non-prototypical nurses, resulting in interesting intra-group dynamics.

7.3   Demonising

The creation of new adapted group identities, as discussed above, developed new sub-groups within the nursing profession: prototypical nurses and non-prototypical nurses. This led to the development of in-groups and out-groups, leading to professional in fighting through undermining mechanisms. Traditional, prototypical nurses demonised non-prototypical nurses by undermining those who were no longer seen as prototypical group members, distanced from their nursing identity by managerial roles and values. Those moving into non-prototypical general management roles, demonised prototypical nurses by undermining them, distancing themselves from traditional nursing roles to legitimise their hierarchical move, and elevate their status and authority with other professions.

118

7.3.1 Demonising Non-Prototypical Nurses

As outlined in the previous chapter, identity conflict can occur during transition into more formal managerial roles, due to a move away from the professional group. Those remaining in clinical roles, who strongly identified with the professional group prototypes, often perceived these individuals as being unable to cope with the demands of a traditional nursing role. In order to protect their prototypical identity, these individuals employed demonisation work through undermining mechanisms aimed at discrediting non-prototypical nurses. They were often portrayed as 'wanting out' of the harder job of traditional nursing work and discussed in a negative manner:

> *They don't want to get up at 6 in the morning and they don't want to work Christmas Day and New Years Night... a lot of people want out of patient contact... People think it's beneath them (Nurse 15)*

> *Nurses who aren't very good clinically are the ones who strive to become managers... Some people can't hack it, the day in day out clinical stuff (Nurse 12)*

Being unable to 'hack it' also led to a perception that these managers were out of touch with prototypical nurses, unable to relate to those still on the frontline of patient care:

> *In order to have any integrity in what you talk about you have to be able to make that connection with the people that deliver it. It makes me laugh when I think about some of the things they used to come out with, and you'd think they'd got not a clue, not a clue (Nurse 13).*

These managerial nurses are almost seen as a threat to the NHS due to their lack of consideration or understanding of front line needs, and the loss of their nursing values:

I have seen people who have been clinicians who seem to have forgotten that bit because it's been squeezed out of them for one reason or another (Nurse 5)

By undermining them in this manner, clinical nurses once again secure their identity as the safe-guarders of patient care, enforcing the importance of their role:

I hope the managers and the clinical directors and clinical leaders within the trust don't destroy the nursing work… there's a lack of understanding of the detail. One of the powers that be within the trust says 'don't bother me with the detail' but it's the detail that's important and it's the clinical detail and the clients and the patients that are the most important people within our service… But how do I get that across to a manager? (Nurse 17).

Patient care is no longer seen as a priority for non-prototypical individuals, undermining their legitimacy whilst simultaneously aggrandising the importance of traditional nursing work:

It's alright having all the files and flowcharts to impress everyone but if your clients are walking around in a filthy state none of it matters. I think the basic nursing care is not as good as it should be because people think it's beneath them (Nurse 28).

Reinforcing this demonising work, respondents often admitted to scape-goating hierarchical managers during team discussions, to deflect negative perceptions of themselves:

How you sell something that's going to be unpopular is a trick isn't it. You know sometimes I play the we've got to do this, we've got no choice, don't blame me it weren't my idea, you know, or we blame somebody who's not in the room, which is a bit disingenuous perhaps…. In team meetings I do have to say the party line whether I believe in it or not. It's real, it's true and it's happening and there's no getting away from it. My last line is we've got no choice in this because these decisions are made above our head (Nurse 15).

7.3.2   Demonising Prototypical Nurses

Whilst prototypical respondents legitimised their own role by aggrandising their clinical contact and demonising managers who had 'sold out', no longer seen as being in touch with prototypical nursing staff, those in managerial roles reciprocated by demonising the clinical staff. These managers with nursing backgrounds legitimised their roles by aggrandising the need for nurses to move into management positions, which was to the benefit of the whole nursing profession and appropriate for patients' needs. Individuals maintained they could achieve greater influence over the service, and over nursing practice, by moving away from the clinical field and into a managerial one, whilst advocating the importance of their salient professional identity. In addition to this aggrandising mechanism, non-clinical nurse managers often demonised the abilities and standards of purely clinical nurses, who were conforming to nursing prototypes. Respondents who had made the conscious decision to move out of clinical nursing legitimised this move by demonising the current state of basic nursing care, and the current standard of clinical nurses:

> *When I trained people were looked after. The ward sister took a pride in the ward and made sure everyone knew what they were supposed to do. Standards were very high. All that has gone. They haven't even got time nowadays you hear to clean beds down between patients when they've had something contagious. Nurses used to clean equipment down that was part of your job. It's not like that now (Nurse 24)*

> *I'm slightly disillusioned with nursing generally about how appalling some elements of nursing are and I've witnessed that myself (Nurse 13)*

In addition to the poor levels of practical care, the level of education and understanding of prototypical nurses (who had not adapted their group membership to take on strategic management roles) was undermined, and a reliance on traditional nursing behaviours portrayed as a negative, rather than positive, attribute in the modern NHS:

> *When you're sick you want somebody who is able to care for you kindly and tuck you up in bed... But nurses have to work in far more complicated environments than just tucking*

121

people up in bed. They have to work within this great organism that is the NHS and they

don't necessarily understand the politics and dynamics (Nurse 19).

It is interesting that this subordinate professional group, with a highly salient identity, engaged in demonising work aimed at fellow group members rather than those outside of the profession. The nursing group ideology is so strong and prevalent it is self-sabotaging, as it undermines those who attempt to take on incongruent leadership roles. Prototypical nurses will find it almost impossible to be seen as legitimate leaders within the wider organisation, and those non-prototypical nurses, who need to adapt their identities to resolve role conflict between the two ideologies, find their group membership and social influence reduced. Whilst aggrandising and demonising work is employed to increase individual legitimacy and protect group influence, used in isolation they do not rectify internal identity conflicts, which are inherent when taking on dichotomous roles. This resolution is attempted through the creation of salience hierarchies, using splitting or fusing work.

7.4   Salience Hierarchies

To overcome internal issues of identity conflict, individuals engaged salience work through splitting or fusing processes. These processes are discussed below, and the resulting identities are explored in the next chapter.

7.4.1   Splitting

Splitting was used by those in conflict to try and reconcile their managerial demands and priorities with their clinical values and expected professional group behaviours. Many reported conflict due to the incompatible nature of those identities:

It's a bit difficult for me to get my head around because I'm not employed as a clinician

anymore and yet I do hold a clinical case load as well as being the leader for the service,

and obviously my clinical work will still be around my professional background but then

I have to be able to switch to leading the service as well (Nurse 11)

Individuals in these roles often reported a sense of dissatisfaction, as they were unable to successfully balance two competing identities, meaning that '*I sometimes feel I compromise my clinical stuff '(Nurse 11).* In order to resolve this conflict, many respondents reported splitting their identities, enabling them *'to see things in two different roles in a way, clinical and managerial '(Nurse 25).* By splitting and compartmentalising their identities into a professional nursing role and a managerial leadership role, conflicted individuals were able to evoke different behaviours and priorities in different contexts, thereby reducing their internal conflict. They acknowledged that they *'tend to sift, mentally sift'* (Nurse 13) and *'ring fence and try and focus on the time and the task. It is extraordinarily difficult to manage'* (Nurse 30).

This situational split created a salience hierarchy for these respondents, allowing them to prioritise the existence of one set of values over another depending on the situation. In this way they could begin to resolve some of the conflicts inherent in their roles:

I do struggle to get my head out of being a clinician and into being a manager. Because I

have to keep both heads at the moment and it's difficult, because it is all about finance

and being able to understand the processes and what targets need to be met... it doesn't

quite fit together for me as a clinician with that. But if I ignore the fact that I'm a

clinician I could probably get my head around it (Nurse 11).

In addition to a reduction of their internal conflict, using situational salience work enabled respondents to attempt to influence others, across a wide range of backgrounds. Switching between salient identities, from clinical to managerial, depending on context could increase legitimacy amongst different groups. Respondents acknowledged actively distancing themselves from the nursing group at times, particularly to increase their legitimacy with more powerful professional groups such as doctors:

123

There are times when I'm in certain circles where it's more useful to talk about being a

[senior figure] than it is to talk about being a nurse (Nurse 31).

By evoking a salient managerial leadership identity, rather than their professional background, individuals were able to attain formal, hierarchical legitimacy and influence they felt unable to achieve through prototypical nursing behaviour. In a similar way, these individuals would revert to a salient nursing identity when attempting to influence professional staff:

I think that if I'm extremely honest if I want to influence nurses and there are nurses in

the room I will tell them that for 8 years I worked on an acute ward and that I have that

experience. I think they think 'oh she'll understand. (Nurse 16).

Whilst this salience work, and the creation of salient hierarchies, avoided some of the internal identity conflicts, the hypocritical nature of this behaviour could potential result in problems. These were related to issues of legitimacy and are explored more in the next chapter, exploring the resulting identity constructions.

7.4.2   Fusing Identities

Whilst the majority of respondents relied upon situationally salient hierarchies through splitting, some did seem able to successfully fuse their identities, embodying them simultaneously. These individuals endowed their managerial and clinical identities and roles with equal importance, with one individual identifying the importance of a transition of salience from a nurse with managerial responsibilities, to a manager with a professional nurse background:

I still see myself as a nurse. I would never lose that as part of my identity but increasingly

over the last year or so I have thought of myself more as being a manager and that being

a professional role. My two professions are being a nurse and being a manager…

Increasingly over the last year or so, my role is as a manager and a leader rather than as

a nurse. Although the nursing but's still there, but seeing that as a profession in itself

(Nurse 10)

Although the managerial element of their identity has increased in importance, their professional identity is a fundamental element of their self, used to guide their actions at all times during their formal, managerial leadership role.

Interestingly, one of the key elements of their professional identity which these individuals managed to fuse with their managerial role was the act of 'caring', previously acknowledged as one of the core nursing ideologies. Whilst they could no longer enact this behaviour in a clinical manner, through patient contact, they managed this fusion by substituting their staff for their patients:

> *I suppose I always thought I'd never be able to move out of clinical practice, that was why I came into nursing and the main reason for getting up every morning... but with the staff I manage it's important for me to keep them well and motivated for the service they provide. I've swapped service users for staff. So that need that I have has been superseded by staff... I still care for people but they happen to be staff and not people who use the service. There's still that direct connection to people (Nurse 14)*

> *I really didn't want to let go of the clinical role because it's quite a rewarding role to have ... I still miss the clinical aspect but I think it's the same kind of skills you use in working with staff. The same empowerment skills, helping people to move forward (Nurse 9)*

Through these substitution mechanisms, individuals were more able to align their professional group values and behaviours with the reality of their managerial role, without one detracting from the other. In this way their professional background was aligned with their formal management role, tempering some of the difficult demands they may face by relying on their professional values to make appropriate decisions:

> *If you don't have an appreciation of what the challenges are in those areas you can't lead if you haven't got people with you and people won't be with me if I don't understand what the needs are and what the challenges are and what the stresses are of their*

particular area… I think it gives me a degree of credibility as well. I think it's more

challenging if you didn't have a clinical background (Nurse 14).

By fusing their identity components these individual could overcome potential conflict, attributing both elements equal salience in all situations.

7.5   Leadership Development

The attempts at conflict resolution demonstrated thus far have been enacted by individuals who are attempting to legitimise their identity to themselves and others. As well as individual resolution attempts, the leadership development programmes which respondents attended could be seen as an organisational mechanism facilitating identity transitions. Some respondents acknowledged the positive influence of the programmes on their developing leadership identity, commenting on the transitional space offered by the courses:

It's good to keep getting the constant messages, the constant positive messages. You need

it, you need that headspace at times because otherwise its very easy to get bogged down

with things, so it gives you that headspace, gives you a chance to think (Nurse 5)

Having time to consider their own identity, and address any internal conflicts was seen as one of the positive outcomes of the programmes. Another was the exposure to potential leaders from different hierarchical positions within the organisation. The two leadership development programmes forming the sites of data collection for this study were discussed in the methodology. There, I acknowledged that whilst they both took slightly different approaches to leadership development, they could be conceptualised as a similar experience due to the commitment to distributed leadership, demonstrated through a stratification of programme participants. For respondents on either of the programmes, the ability to met with other people from different areas of the trust was seen as a positive element of the distributed nature of the course:

I think it's like a forum, a sharing thing, a networking thing (Nurse 31)

I would say it's an insight into how things operate and it has been an opportunity to network with a lot of people which was invaluable really… I think this is more kind of, more of an experience than a course as such. Which is equally valuable because it's a different way of learning (Nurse 9)

The space offered by the leadership programmes was therefore seen as an opportunity for networking, and as a theoretical space in which individuals were encouraged to consider their own leadership identity and role. For some, the experience was seen as particularly beneficial to their sense of self and increased their organisational commitment:

It's the sense of community that it brings I think. Because, actually it opens your eyes up to a huge amount of information about that big organic thing I talked about, the NHS. And that sense of belonging, I feel very committed to (the trust) and a sense of belonging… getting people to align themselves with the vision, it's almost getting people converted, it's like a religion (Nurse 13)

However, not all respondents saw the experience of being 'converted' in such a positive light. These nurses did not appear to have addressed their own identities in the same way, and often reported a sense that they did not gain anything from the courses. Some questioned the true motivations of the programmes, suggesting it was primarily a mechanism of organisational control:

In some ways it was a big sort of PR thing for the trust… it was that whole sort of megalomania thing. I mean I came away at the end and I've got this big fancy folder of things and its quite hard to pinpoint at times whether you've got a nugget to take away with you (Nurse 11)

I think it was important people letting us know how important they are… Because we were sold this vision and now what we were told and then what's actually happening are two very different things (Nurse 17)

The sense of organisational control was reported by many respondents, suggesting that the programmes were not really able to facilitate identity transition, and were instead attempting to standardise behaviours to achieve organisational priorities:

> *I did have a feeling that it was like, right well we'll get everybody together here because we know what's coming. (THE CHIEF EXEC) actually used the words a 'tsunami of change'… And I just thought we're all being briefed here, we're being got on side, we're being got here and trying to be made special so we go and do the dirty work (Nurse 15)*

As a result, the majority of study participants seemed unsure about the benefits of attending the leadership development courses. This was compounded by their pre-existing identity conflicts and exacerbated by the organisational context which reduced the efficacy of the programme in resolving some of these identity issues:

> *And I came away from that thinking well how does that actually make a difference, talking the talk what I have sometimes experienced in real life. And I worry about how that gets through and how people are really able to look at themselves as leaders and say 'well what do I need to improve on and what do I need to do better' (Nurse 11)*

According to the majority of respondents the programmes had a limited impact on facilitating identity conflict resolution. For some, the combination of the theoretical space to confront their leadership identity, and the benefits of organisational networking, helped them to feel supported in their role and committed to the trust. However, the majority reported a sense of organisational control, and a concern that the priority was on conforming to organisational agendas and visions, rather than developing their own leadership identity. As such, these individuals had to rely entirely on their own attempts at conflict resolution, and saw the benefits of the leadership development programmes as limited. This limited impact is also reflected in the finding that none of the respondents changed their identity constructions over the course of the study. The conflicts encountered, identity work engaged in, and resulting constructions were the same in the first and

second interviews. This highlights the negligible impact that the leadership development programmes had on mediating or facilitating identity transition and constructions.

7.6   Conclusion

The data explored in this chapter has addressed the identity work processes used by respondents to overcome the conflicts identified previously. All individuals engaged in aggrandising work, through self-enhancement, to elevate their professional background to a higher moral level, thereby endowing it with a sense of legitimacy and importance. Whilst those in traditional work roles could maintain a prototypical identity, those moving into more managerial roles had to adapt their group membership in order to be seen as influential. These respondents subsequently engaged in secondary aggrandising mechanisms to legitimise this transition. Although this allowed individuals to associate a positive sense of self with their adapted identity, it also resulted in the creation of sub-groups within the profession. This led to demonising work through undermining mechanisms, used by prototypical nurses to protect and maintain the importance of their traditional identities, and used by non-prototypical nurses to undermine the traditional group ideology. Horizontal violence and in-group fighting were clear during interview discourse, as nurses directed their demonising work at other group members, rather than true out-groups.

The use of salience hierarchies through splitting or fusing was also identified. Splitting identities and employing a situational salience hierarchy enabled respondents to embody different identities, according to audience and context, potentially reducing conflict by using values and behaviours appropriately. Fusing identities allowed respondents to portray both managerial and clinical elements simultaneously, using them together in all situations to guide actions. The outcomes of these conflict resolution mechanisms are discussed in the next chapter, which considers the identity types constructed and their success in conflict resolution and potential leadership influence.

8 Identity Constructions

8.1 Introduction

In this final empirical chapter I address the third element of the research question: What are the resulting identity constructions? The attempts at resolution of conflicts, as outlined in the previous chapter, resulted in the construction of different identities. Table 8 shows a typology of the resulting identities, the types of identity work used in construction, and the success at reducing identity conflict and achieving influence. This chapter highlights responses from individuals who were seen as clear representations of these identity categories.

Table 8 - Identity Constructions					
Self Enhancement	**Out-group Undermining**	**Identity Salience**	**Resulting Identity**	**Level of Identity Conflict**	**Type of Influential Leadership**
Limited Aggrandising	Demonise non-prototypical nurses	Reject managerial leadership identity	CLINICIAN	None	Informal, professional
Reject group membership	Demonise prototypical and non-prototypical nurses	Reject professional identity	MANAGER	None	Formal managerial
Aggrandise prototypical professional identity AND adapted group membership	Demonise non-prototypical nurses AND prototypical nurses	Evoke different identities in different situations	SPLIT HYBRID	High	Conflicted managerial, unsuccessful professional
Adapt group membership but acknowledge important professional background	Limited demonising	Personify adapted professional identity and managerial leadership identity simultaneously	FUSED HYBRID	Low	Formal managerial and informal professional

Clinician, Manager, Split Hybrid and Fused Hybrid are the labels attributed to the identities represented in the data. This chapter considers these identity constructions and the success of the identity work associated with them.

As mentioned above, it is worth noting that the study was conducted longitudinally to determine how leadership development programmes could mediate the difficulties that individuals may face when constructing leadership identities. In these results chapters, I have not discerned between first and second interviews. This is because during the course of the study the identity constructions of individuals did not change. Their identities remained the same, despite their attendance at a leadership development programme. The implications of this are discussed in greater depth in the discussion chapter.

8.2   Clinicians

Respondents in positions enabling them to enact traditional nursing roles, clinical patient contact without any managerial demands, were able to construct a 'Clinician' Identity. Primarily relying on demonising work to undermine those in non-prototypical roles, clinicians rejected the possibility of a managerial identity and actively chose to retain a more prototypical nursing identity. Whilst they could enact some informal, professional leadership within their clinical teams, they were unable to take on leadership roles outside of the profession, due to their lack of influence within the wider organisation. Two respondents who constructed the clinician identity are considered in detail here, Nurse 12 and Nurse 5. Both of these individuals were in direct clinical roles with no managerial responsibility, and had been in these roles for some time whilst other colleagues had moved into managerial positions.

Although their professional identity was central to their role, these individuals did not aggrandise their background to the same extent as the hybrid constructions, as discussed later. Clinicians seemed confident in their salient prototypical professional identity and did not legitimise their

identity in this way, possibly because it was evidenced in their day-to-day role. Instead, they primarily employed demonising work to undermine non-prototypical nurses. Those non-prototypical nurses who had moved into management positions were called '*dictatorial little Hitler's' (Nurse 12)* and seen as being out of touch with the core ideals and values of their nursing identity:

> *The management roles have increasingly become about chasing people's figures and sorting out a lot of admin type things, and it's easy for the nurses on the ground to feel disgruntled… sometimes you worry that to them it's more about the figures and numbers (Nurse 12)*

Non-prototypical nurses were perceived as moving away from the hard reality of clinical nursing roles, a move primarily related to failure to be a good clinician:

> *There's something, there's a bit of envy when you see people in glossy jobs wandering around corridors and not seeming to do very much… There is a lot of resentment with nurses definitely… There's the cliché of those nurses who aren't very good clinically are the ones who strive to become managers… If you're not very good with people you go into being a manager! (Nurse 12)*

The salience of their professional identity, combined with the demonising work to undermine those in managerial roles, is used by clinicians to legitimise an active rejection of any managerial element to their identity. They split, and then created a singularly salient identity, rather than a salience hierarchy. Both Nurse 12 and Nurse 5 were clear about the lack of a desire to hold a formal, managerial leadership role, which would detract from their salient, prototypical identity. Interestingly for Nurse 5, they had previously held a managerial position before making the decision to move back into a clinical role, more in line with their salient identity:

> *I wouldn't move back into the team leading side of things, to go back to more clinical was the right decision for me. So at the moment I'm just enjoying my job really… The*

management side of things for me is the cause of a lot of stress... I'm happy where I am at

the moment (Nurse 5)

InNur11 had never held a management post but was clear that their clinical role was fulfilling

enough for them:

I've never really wanted to climb to great heights and work full time, to want to climb to

be team leader. I haven't' got the heart for it. I'm competent in knowing I can do a good

job (Nurse 12)

The association of management with negative events, and the subsequent rejection of that

identity, was commonly seen among Clinician respondents. One nurse who had already moved

into a middle management position reflected on the negative perceptions of 'management' held by

clinicians, exploring the motivations of staff who had actively rejected the label of 'manager':

Some people like to be very clear that they're a leader and not a manager. For example,

we have a senior nurse and some senior social workers here who are very clear that their

role is leadership and not management... some people very much would not ever want to

be managers and don't want that managerial sort of negativity attached to them (Nurse

10)

This rejection of a 'managerial' identity, which was seen to have negative connotations for those

individuals constructing a prototypical clinician identity, led to these respondents experiencing

low levels of internal conflict, as they did not have to reconcile any conflicting demands. This was

demonstrated above, where Nurse 12 and Nurse 5 reported feeling happy and content with their

roles, and clear about their identities. However, these low levels of conflict were coupled with low

levels of leadership influence. It was almost impossible for clinicians to enact any leadership

outside of formal, managerial positions, meaning that their contribution was limited to informal,

professional leadership:

I wouldn't see myself as much of a leader in the role I'm doing now but I work with staff

who are not qualified and ask my advice and opinion on things so I guess in that respect.

But whether that's a leader or providing support I'm not sure. I guess you lead by example and for them to be asking your advice… I acknowledge that some of what I do is leadership but I think with having changed roles I see myself as less of a leader in this current role but I acknowledge we all lead wherever we're coming from (Nurse 5)

I haven't really taken a leading role… If I feel secure within a team I'll take a role of leadership in a small way… take some responsibility for sorting things out or giving some support to others and those sorts of things… but I wouldn't want to be the leader, even of a small team really (Nurse 12).

Clinicians are characterised by their salient, prototypical, professional identity. Rather than relying on aggrandising work to legitimise their identity, they primarily used demonising work to undermine non-prototypical nurses. In this way they were able to enhance the importance of their prototypical behaviour and justify their decision to reject a managerial, non-prototypical role. Whilst this reduced the potential for internal conflict, allowing prototypical nurses to remain in prototypical roles, it means that clinicians are only able to enact informal, professional leadership. They had limited influence within their clinical teams and no influence outside of their professional group. However, this does not mean that all nurses will never encounter identity conflicts. Many nurses clearly make the decision to move into increasingly managerial roles, often experiencing identity conflicts as they attempt to do so alongside their professional group membership. Whilst most study respondents entered into these dual clinical-managerial roles, a small proportion of clinical nurses were dissatisfied with their limited leadership potential within their professional role and felt constrained by their professional identity. This limited group of individuals will actively move away from any clinical role and seek out general management jobs, splitting their identities to favour a salient managerial identity.

8.3   Managers

One respondent (Nurse 23), previously constructing a 'Clinician' identity, was explicit in their dissatisfaction with their nursing role and identity and was keen to move towards a more managerial stance:

> *I think in the future that's they way I want my career to progress, away from the clinical*
>
> *area and towards more budgeting and project management, that's what interests me...*
>
> *When I qualified I was enthusiastic and I enjoyed the job and now my interest is on the*
>
> *more business side of healthcare and the fact I've not been able to do that has made me*
>
> *less interested in the clinical side of the work which is why I'm working towards going in*
>
> *that direction. Once you go in that management and go away from direct clinical care*
>
> *it's difficult to get back into it but I don't think I want to anyway (Nurse 23)*

A small number of individuals were seen to construct 'Manager' identities, rejecting their professional identity and distancing themselves from the nursing profession entirely. The responses of two individuals who held formal managerial positions with no clinical elements, Nurse 24 and Nurse 7, are explored here. These individuals had made a conscious decision to move themselves out of the nursing professional hierarchy:

> *The clinical role wasn't what I wanted anymore and once I made that decision it was*
>
> *clear-cut in my head (Nurse7)*

To legitimise their role they engaged in savage demonising work to undermine the whole nursing profession. All nurses were perceived as elitist, a group that these respondents no longer had any desire to belong to:

> *I wouldn't consider going back into clinical because it's not worth it, it's hard work and*
>
> *the staffing levels are being cut... Nurses are up their own arse, they've got this thing*
>
> *about I'm special... you're not special (Nurse 24)*

> *Especially with clinicians. I just think there's an elitism and a club that they belong in*
>
> *that we don't (Nurse 7)*

The motives and abilities of prototypical nurses were questioned, as discussed in the previous chapter, undermining their claim to prototypical nursing behaviour:

Some of the attitude that I've heard is that the nurses have said I'm not doing 3 years of training to shovel shit, that's the attitude of some nurses (Nurse 24).

The core values of prototypical nurses are thereby undermined, reducing their legitimacy as caring, altruistic individuals – the central ideal of their professional identity. Nurses who had moved into non-prototypical management roles were also attacked, undermined through demonising work which painted them as incompetent due to their professional background:

There's a lot of middle management positions, team leaders, throughout the trust that don't have the skills in how to manage a budget, you know your basic skills of management (Nurse 7)

In the main management tends to be weak and crap. Just because you've done nurse training doesn't mean you'll be good at management and I don't think people should be going into management if they haven't got the aptitude and the abilities (Nurse 24).

Managers therefore engaged in demonising work to undermine the entire nursing profession and distance themselves from it. Nurse 7 was clear about their conscious move away from anything resembling nursing care (as shown previously), taking on a role which was totally uncoupled from their professional background. Interestingly, for Nurse 24 it was not the nature of the nursing work she demonised, but the actual profession of nursing. This respondent still saw themselves as a 'carer' and engaged in informal caring work, but was clear about their rejection of the title 'nurse' and any association with the nursing profession:

I still do respite care with a young man. I'm very much a carer but I do that as a personal assistant for the young man, not as a registered nurse. I see myself very much as a carer. I don't need the title nurse. It's got a medical connotation to it... the title of a nurse, the medical model is wrong. The nursing care's gone out of nursing. We've lost the

136

fragrance of what we're about. And I don't like being tarnished with that brush because

that's not what I'm about (Nurse 24)

In a similar manner to the clinician identities, managers experienced relatively little internal conflict as they rejected one aspect of a potentially conflicting identity, to create one of singular salience. They employed effective identity work to legitimise their move away from their nursing background, and did not feel conflicted about this rejection. However, removing themselves from the professional nursing hierarchy meant that these individuals no longer held an informal professional influence. They could no longer evoke the collegiality of a shared professional identity to influence others, relying instead on their formal management position which had limitations:

I don't know whether I have a leadership role or more of a managerial role... I can't set

the vision particularly because I'm working for an organisation so I can steer them, lead

them in visions that have been set by other people but they're not my visions. I'd say I've

got a management role (Nurse 7)

Managers have removed themselves from the nursing profession, rejected their professional identity and adopted an unconflicted managerial identity. As such they occupy formal management positions which dictate the extent of their organisational influence, relying on hierarchical power rather than group influence.

8.4   Split Hybrids

Clinicians and managers were able to construct unconflicted, singular identities due to the nature of their roles, which facilitated those constructions. The majority of study respondents were in 'middle management' roles, requiring them to combine managerial and professional demands and values. Respondents in these positions either constructed a fused hybrid identity, discussed later, or a split hybrid identity. Split Hybrids made up the majority of interview respondents, characterised by high levels of internal conflict and low levels of professional and organisational

leadership influence. Primarily, these individuals faced a discrepancy between the managerial demands of their role, requiring them to adopt leadership behaviours and conform to managerial values, as well as the values and ideals of their traditional, professional background which was still salient.

Whilst clinicians did not need to engage in aggrandising work to legitimise their role in the context of their professional background, split hybrids did. Their professional ideals were aggrandised as a crucial element of their identity, and they were keen to highlight the importance of their nursing background despite their managerial role:

> *I'm a nurse. That's my profession. Although nurse doesn't appear in my job title now, I'm a manager now. But as far as I'm concerned I'm a nurse and I still enjoy my clinical duties. I still enjoy sitting down with patients the most…. I trained to be a nurse, I went to university to be a nurse (Nurse 22)*

By aggrandising their professional background, split hybrids attempted to retain some degree of prototypical behaviour, which was congruent with their nurse identity, and were often quick to point out that they were still able to connect their work with indirect patient care:

> *I wouldn't want to go any further away from nursing than I am now. When I look at other paths that people have taken, nursing is great because it can take you anywhere. People go into strategic posts, and that's great, but that's not why I came into nursing. I didn't want to have a job like that, I wanted to be a nurse. At the moment I still see the patients, albeit with no clinical responsibility (Nurse 25)*

Alongside this need to aggrandise their prototypical behaviour (although in non-prototypical roles), split hybrids also attempted to aggrandise their non-prototypical behaviour. As mentioned in the previous chapter, this was achieved by adapting their group membership, aggrandising their new potential for greater strategic influence, achieved by stepping away from a prototypical role:

I was ready, I was de--motivated, I was coming to work just for the money, wasn't

particularly interested in the work at the time, it had just got boring really and I knew I

could make a bigger difference in a managerial role. Which I have (Nurse 6)

Aggrandising work was therefore used simultaneously to advocate prototypical ideals and values alongside non-prototypical behaviours and adapted group memberships. This conflicting identity work was compounded by similarly conflicting demonising work. During interviews, split hybrid individuals would switch quickly from aggrandising their similarities with front-line traditional nurses, to undermining them:

Staff on the wards who have all the baggage and attitude and issues that nurses have

and, to be honest with you, questionable practice standards of practice (Nurse 30).

This demonising work was not only limited to prototypical nurses. Other split hybrids were also the focus of this identity work, and respondents would often attempt to undermine those in similar middle management positions to themselves, usually without recognising the paradoxical nature of their attitudes:

Even though I'm a nurse, I tend to have quite a negative idea about leadership in

nursing, or nurse leaders, because I think so many that I've come across have been

dreadful. It seems that some people can't wait to get out of clinical, and they go into a

management job and they're just hopeless at it, and they're either dreadful and they

don't realise and piss everybody off, or they're dreadful and not supported and they're

left to flounder and they go off on long term sick (Nurse 26)

There's a sandwich filling of nurses who may have been brilliant clinically but are

absolutely rubbish managerially… I see a lot of people like that who would have been

good nurses but they're in these jobs and I think, what exactly are you doing? I've no idea

what half of them are doing… there seems to be a grey area above nursing and below

senior management, where some nurses who are rubbish drift around doing goodness

knows what (Nurse 25)

Nurses who had moved into managerial roles and were no longer prototypical were undermined as split hybrids engaged in demonising work to highlight the idea that nurses should remain on the wards, again seemingly unaware of the hypocrisy of their discourse:

> *There are some truly great clinical nurses out there. I think it's a shame those great nurses don't stay on the wards (Nurse 24)*

> *Some people do their nurse training and they don't do any clinical work and the next time you see them they're in some super high flying job in the trust and they haven't done any clinical work and as a nurse you think how did that happen? How can you possibly tell me about nursing when you haven't done it? (Nurse 25)*

Split hybrids therefore engage in contradictory aggrandising and demonising work in an attempt to legitimise their non-prototypical role to themselves and others, reflecting the internal conflict they experience when attempting to resolve the discrepancies between their professional values and desire to be seen as prototypical, and their new managerial demands. To overcome these conflicts, split hybrids created a salience hierarchy by splitting and compartmentalising their clinician and manager identities:

> *I split the two. I'm very clear where my clinical boundaries lie and where my managerial duties take over… I'm very aware I will do both, but I put it into compartments and that's how in my head I see my work (Nurse 22)*

Whilst this splitting work was often the only way these respondents could begin to tackle the demands of their roles, a compartmentalised identity often caused logistical issues for these individuals as they attempted to switch between salient identities:

> *On a day by day basis I have a lot of interruptions from staff and patients which draws my attention away from what I'm doing, it takes time once you've withdrawn to switch on to what that person wants you to do and then switch back to what you were doing… that affects the amount of time I have (Nurse 6)*

Subsequently, the internal conflict felt by split hybrids is compounded, as they feel unable to fulfil both aspects of their role adequately:

> *I'm a bit of everything aren't I, a bit of everything. But it would be nice to be, when I'm on the shift as a nurse to just be a nurse, and when I'm on management day to just be a manager rather than have to do this, split it up. And then you feel like am I giving which every role I'm in my best? (Nurse 10)*

Often it was the concern about a loss of their prototypical nursing identity which caused the highest amount of internal conflict for respondents, lamenting their inability to still be seen as a prototypical member of the group, despite their best efforts:

> *I do struggle when people ask me what I do; I still say I'm a nurse… I always thought I'd never be able to move out of clinical practice, that was why I came into nursing and the main reason for getting up every morning… It worries me that professionally I might be deskilled so I don't know what I can do about that because I don't have the time to do anything else (Nurse 4)*

> *I've always taken pride in being a nurse, I like being a nurse. I've always liked that that's part of my identity. Now I'd hate to think I'm not a nurse. I like to think that someday I may go back to nursing, I may not… I do struggle with that sometimes. I try and convince myself that there are aspects of the job which are still nursing, as few and far between as they are… I'd hate to think I'd never have clinical contact again (Nurse 25)*

Split Hybrids feel pulled in different directions due to their desire to maintain a prototypical identity in a non-prototypical role. As such, they often admitted to feeling confused about their identity:

> *I don't know. I think I'm a role model for a view of the world. I don't think it's nursing… I don't do any nursing as such… I do reports and investigations and policies and procedures, I teach, I'm on national groups. I think I'm a spokesperson or representative of a profession but no… I'm lots of little bits of other things (Nurse 13)*

Their inability to leave behind their desire to be seen as prototypical nurses, despite being in non-prototypical roles crated large amounts of internal conflicts for these respondents, and ultimately undermined their potential leadership influence. They often felt ineffective when attempting to resolve role demands, giving neither aspect of their roles enough attention, and also reporting negative attitudes from staff who remained in prototypical roles:

> *They mostly think I don't do a proper job and they don't... I sometimes get the feeling when I say I'm busy at work or it's stressful they don't necessarily think my job is stressful compared to theirs... as much as it saddens me to say, I think they probably view me as someone who used to be a nurse (Nurse 25)*

Split Hybrids are characterised by their conflicted identities, causing them to engage in contradictory identity work. They simultaneously aggrandised their prototypical identity alongside their non-prototypical, adapted group membership. The used demonising work to undermine the front line, traditional nurses they had previously aggrandised, as well as demonising those who moved in non-prototypical, middle management roles similar to their own. In an attempt to resolve the identity conflict inherent in their roles, they constructed a salience hierarchy by spitting their identities into 'clinician' and 'manager', personifying different personas depending on audience and context. However, this did not resolve their identity conflicts and in some cases actually increased them. Their professional leadership influence was reduced, due to their contradictory and sometimes hypocritical behaviour, and their organisational influence was limited due to their unresolved identity conflicts.

8.5   Fused Hybrids

The second type of hybrid construction were fused hybrids, individuals who had taken on formal management positions with large amounts of hierarchical power, but who used aggrandising work to highlight their continuing allegiance with their professional background. Whilst split hybrids were unsuccessful in their maintenance of a prototypical identity, fused hybrids acknowledged

their non-prototypical roles but aggrandised the use of professional values and experiences to guide them in their managerial roles:

> *It influences my decisions. It influences the way I talk to clinical staff because I know of the experience I've had I can put myself in their shoes even when there is a big gap between when I did it and now… I think the decisions I make are influenced by that (Nurse 14)*

> *My total experience of nursing has an affect on everything I do in life… I don't think I'll ever lose the reasons I went into nursing, which was to become a carer for people, and that is my identity and I don't think that will ever change. The empathy and the vocation you go into and the reasons you go into it will never change. I still apply that when I'm [*managing]… In a different sense because I'm not caring for them but you still apply that same people values and skills from nursing (Nurse 16)*

As a result, individuals in this category were able to achieve effective leadership influence, both within and outside of the profession, due to the maintenance of their group membership combined with formal, managerial roles. By explicitly stating their professional background to people, they were seen as sharing an identity with others in their social group, thereby achieving group influence:

> *I use my managerial job title but I would utilise that information in some settings if it seemed appropriate. People might ask me directly or if people were talking about their challenges I would say my background is in nursing, I worked on inpatient units, I do appreciate what you're saying (Nurse 27)*

> *I always found having a clinical background was always very subtly helpful if you like because people would turn round and say 'you're a nurse aren't you'… but I don't go into situations and overtly say I'm a nurse because I've been away from that for quite a long time (Nurse 16)*

143

Crucially, the managerial and professional elements of fused hybrid identities were not competing with each other for salience, but were working synergistically to guide all aspects of their strategic roles:

> There is a balance between the two but one doesn't block the other, one will guide the other. The clinical context will guide how the case is managed, and the management of that will guide where it goes clinically as well. There are links between the two but I don't think they contradict. I think they play each other off rather than contradict. (Nurse 19)

The idea that they have a dual, fused identity rather than a split one is crucial for these individuals as it offers an understanding of how they mediate their roles. Most of these individuals no longer had any clinical contact, but were able to resolve that due to their reliance on their professional background to guide their managerial responses:

> I really didn't want to let go of the clinical role because it's quite a rewarding role to have and I tried to carry on with some clinical work. After a year of trying to do that I realised I really couldn't do that and run a team at the same time because it pulls you in too many directions… I still miss the clinical aspect but I think it's the same kind of skills you use in working with staff (Nurse 9)

This respondent had made the difficult decision to move further away from clinical work, in order to become more strategically effective, but as a result they felt satisfied with their contribution:

> I do like a personal challenge. I think moving into a more senior post provides more challenge and satisfies me personally in that way. Also I feel very passionate about services and I think if you're in a position of influence you have a chance to be able to change things and make things operate in a way that they should do. It gives you more power than in a junior position (Nurse 9)

144

The synergistic nature of the two aspects of their identities, combined with a sense of wider organisational influence due to their managerial position, meant that individuals reported low levels of internal conflict:

> *Yeah. I feel I'm doing something that's making a difference. Exactly the same feeling I had when I was a clinician... I'm quite happy really (Nurse 19)*

In addition, by being seen to actively acknowledge their group membership, fused hybrids continued to enjoy positive perceptions from other group members lower in the organisational hierarchy. As previously identified, non-prototypical nurses are often demonised by group members, as they no longer fulfil the group ideology, a problem encountered by split hybrids. Fused hybrids did not encounter these issues, and their leadership often inspired other group members:

> *I think she's a really inspiring leader, I think she's really good... she talks to you on your level, you can relate to her, and she just seems so proud to be a nurse she then makes you realise what an important role you actually play and how... she makes you very proud to be a nurse and makes you want to be like that too (Nurse 14).*

The fused hybrid discussed above was seen as a true leader, an advocate of the nursing profession, and a skilled manager who could work at the highest strategic level of the trust. This allowed her to exert influence at all hierarchical levels and maintained legitimacy, as others perceived her values to be aligned with their own salient identity:

> *It inspires me, it makes me feel better, it makes me feel confident that there's people in higher places, who know what they're doing and whose motivations I trust completely and with hers I can (Nurse 15).*

Fused Hybrids overcome potential identity conflicts by adapting their professional group membership, allowing the fusion of a managerial leadership identity with their professional identity. By accepting their adapted professional identity they no longer strive to be prototypical members of the group, but use the group values to guide them in their managerial roles. They are

145

explicit about the importance of their managerial work, but do not allow one identity to become more salient than another. In this way, fused hybrids achieve legitimacy both within the organisational hierarchy, due to their formal managerial positions and appropriate leadership behaviours, but also within the nursing profession where they are seen as successful nurse leaders. How individuals achieved this transition from split to fused hybrid is unclear. One respondent suggested it was linked with maturity and experience:

It's something that you mature into. This is something that you grow into. What I realise is now, with much hindsight, maturity is incredibly important… there's a lot of learning that needs to take place around politics and the organisation… I think it's part of maturity and learning (Nurse 16)

This sentiment, that the construction of a fused identity could only be achieved over time, through experience and knowledge of the organisation, suggests a reliance on hierarchical roles and formal influence. It is unclear exactly how this transition occurs, and this will be discussed further in the discussion and conclusions chapters.

8.6   Conclusion

This chapter has explored how the types of identity work identified previously are used in different ways to create a typology of nursing leadership identities. Using aggrandising, demonising and salience work, respondents in this study constructed one of 4 identities: clinician, manager, split hybrid or fused hybrid. Clinicians and managers held roles enabling them to reject a potentially conflicting aspect of their identity, the managerial or professional, to embody a singular, salient identity. Whilst this may reduce their potential for internal identity conflicts, it limited their leadership potential, with clinicians relying on informal, professional influence and managers relying on their formal, organisational power. Respondents in middle management roles were unable to reject one aspect of their identity, as they were faced with managerial and clinical demands. These individuals either split or fused their identities. Split hybrids compartmentalised their identity into clinical and managerial, in an unsuccessful attempt to reduce identity conflict. In

addition to the internal conflicts they faced, their hypocritical and contradictory behaviours reduced their leadership legitimacy and potential, both within and outside of their professional group. Fused hybrids were more successful in their identity work, combining their managerial and clinical elements into a new identity. They valued both aspects of their identity equally, using one to guide the other in all situations. Their acknowledgement of their non-prototypical behaviour, coupled with their strong sense of affiliation with the nursing profession, gave them large amounts of influence amongst nurses. Within the wider organisation, the strong managerial aspect of their identity and their hierarchical power gave them influence and leadership potential outside of the professional group.

9   Discussion

9.1   Introduction

I now explore the findings of the previous empirical chapters within the context of existing knowledge, identifying the main areas of interest developed by the study. This chapter demonstrates how the results relating to areas of identity conflict support assumptions arising from the literature review, but findings about the types of identity work used, and resulting constructions, challenge existing research about identity construction among professional groups. The four identity types arising from the identity work are examined, as are the resulting outcomes with regards to identity resolution and meaningful leadership influence. Contributions, implications and development of practice, theory and policy are addressed later, in the final conclusions chapter.

9.2   Where are the Identity Conflicts?

The findings of this study demonstrated that respondents at all organisational levels, and within different job roles, were encountering some degree of identity conflict when attempting to take on managerial leadership identities. Through analysis of interview recordings it was evident that these identity conflicts were related to the low-status of their professional groups within the organisational context. As discussed later, the relationship between medicine and nursing also perpetuated the subordinate nature of their professional identity, causing conflicts for nurses attempting to take on leadership roles. These identity conflicts were related to two key themes: socialisation of the individual into a professional identity whose prototype was at odds with implicit leadership theories (intra-group issues); and the difficulties arising through interaction with other, more powerful professional groups (inter-group issues).

Almost all respondents discussed a strong sense of affiliation and personal identification with their professional background. The high levels of salience associated with their membership of the

professional group engendered a strong sense of psychological commitment to the construction, maintenance and projection of that identity amongst respondents. They demonstrated behaviours associated with salient group identification such as in-group favouritism and prototype aspiration (Ashforth & Humphrey, 1993; Ellemers et al., 2002; Hogg et al., 2003; van Knippenberg et al., 2004). These behaviours were displayed through assertions that nurses needed to be led by nurses, who had been promoted from within the profession, rather than being brought in from other professional groups. As a result, individuals who were seen as highly prototypical enjoyed high levels of social influence and informal leadership within the group, and were subsequently ideally placed to emerge as legitimate, formal leaders from within nursing teams. Whilst not the only factor associated with leader emergence, the importance of embodying a prototypical ideal to achieve group influence has been previously demonstrated as essential amongst highly salient groups (Hogg, 2001a). This study identifies this process of professional leader emergence due to prototypicality, followed by a move into non-prototypical, managerial leadership, as the primary source of identity conflict, with lasting effects on the ability of the individual to construct a successful leadership identity.

9.2.1   Intra-group Issues

As acknowledged, the in-group favouritism associated with their salient professional identity meant that successful leaders needed to emerge from within the profession. In keeping with this assumption, results showed responses from individuals who had initially emerged as informal leaders within nursing teams, before being formally promoted to management positions. This was due to their prototypical behaviour, which afforded them group influence and endowed them with a sense of group support and belonging. Problematically, the aspirational prototype within nursing continues to rely on passive, feminine ideologies which discourage the adoption of more masculine behaviours associated with managerial leadership (Chua & Clegg, 1989; Dingwall et al., 1993; Kreuger, 1978; Lord et al., 2001a; Mackay, 1989; Whittaker & Olesen, 1978). By moving into positions of formal management, individuals were required, at least in part, to enact these masculine, managerial style behaviours and move towards identity constructions which

reflected leadership schemas in order to be perceived as legitimate, effective leaders by other organisational members. This, combined with the acknowledgement that moving up through the nursing hierarchy is associated with a move away from clinical work and direct patient contact, meant that nurses in positions of managerial leadership were seen as ambitious and keen to move away from, and above, the rest of the nursing team – a negatively perceived action.

The move away from clinical care and patient contact was an important aspect of identity conflict at the group and individual level. The practice of nursing and the act of working on the 'shop floor' is a crucial element of their professional identity. By not fulfilling this traditional role, nurse leaders are seen as out of touch, and can experience a reduction in their group credibility (Bolton, 2000; Forbes & Hallier, 2006). Whilst other professions are able to marry their traditional role with their managerial leadership (Llewellyn, 2001; Witman, Smid, Meurs, & Willems, 2011), this study demonstrated that the opportunities for this within nursing were limited. The physical removal of these individuals from the ward into managerial offices further demonstrated their elevation out of the traditional group. These individuals are no longer viewed as prototypical of the group ideology and struggled to exert in-group influence, particularly over their colleagues who maintained a strong prototypical identity.

In addition to the lack of group level influence, which can cause conflict with prototypical nurses, many respondents encountered high levels of internal conflict associated with a sense of loss of group membership. Identity conflict will occur when role or identity boundaries are moved or intruded upon, resulting in a discrepancy between current identity and aspirational identity (Kosmala & Herrbach, 2006; Kreiner, Hollensbe, & Sheep, 2006). In this case, there was conflict between socialised values and behaviours, and their new role and expected management behaviours. This means that modern nurses are now required to occupy dual, sometimes paradoxical, roles as they attempt to construct an identity which combines their historical group ideology with modern professional values and hierarchical managerial leadership positions, which

150

some worry may erode their core professional ideologies and values (Apesoa-Varano, 2007; Baggott, 1998; Cott, 1998; Gunz & Gunz, 2007; Pratt & Rafaeli, 1997). The results indicated multiple concerns about how to marry their managerial and clinical demands within one identity construction, in a way which fulfilled their job role, whilst staying true to their professional self, concerns which have been reported in other research relating to nursing management (Currie & Procter, 2005). Many respondents also felt their identity was unstable and fragile, reporting feelings of a loss of group support and collegiality, reflecting a sense of loss of part of themselves and the feeling that their professional identity was being challenged.

At the group level, potential leaders found themselves in a paradoxical position. By being identified as a leader due to their prototypical behaviour, and associated group influence, they were elevated out of the group, immediately encountering increased resistance and suspicion from other group members who now viewed them as less credible, due to their association with 'management'. These results clearly demonstrate that, through the very act of emerging as leaders, individuals who once held high levels of influence due to their representation of the nursing ideal, were no longer seen to personify this ideal and therefore held less legitimacy. Their distance from clinical work, the role traditionally used to define nurses, combined with the need to demonstrate managerial behaviour to achieve organisational influence, further compounded this problem. The results demonstrated an awareness of a professional culture which discourages leadership behaviours, as they are at odds with its traditional ideology, reliant on subordinate behaviours in relation to the more powerful medical profession.

9.2.2   Inter-group Issues

The informal powers of medicine within the organisational hierarchy, and the formal power of management and central government control, have particular influence over nursing hierarchies and leadership potential (Cameron & Masterson, 2000; Campbell-Heider & Pollock, 1987; Chan, 2002; Reeves et al., 2010). Over the course of the study, many respondents

commented on the recent Government austerity cuts, which had seen formal nursing leadership posts removed, reflecting the lack of influence and importance given to nursing leadership. This undermining, alongside the constant promotion of medical professional leadership, are organisational barriers which are historically and culturally entrenched in the National Health Service, and are difficult for nurses to redress (Reeves et al., 2010). Study respondents from all hierarchical levels noted this assumption, and often alluded to the feeling that they were constrained by organisational boundaries. As identified in the literature review, organisational contexts can shape identity constructions by acting as arenas for social interaction, defining boundaries and acceptable types of identity work (Ibarra, 1999; Svenningson & Alvesson, 2003). This was particularly evident in this study in interactions with doctors, where respondents felt undermined due to their professional background, even when in formal management positions with high levels of hierarchical power.

Whilst these results relating to inter-group dynamics were expected, the study did illuminate some interesting findings about nurses' role in maintaining the organisational structure and perpetuating the hierarchical culture. As previously acknowledged, nurses rely on the maintenance of their traditional group ideals and symbols to define their professional identity. As such, their core identity relies on the maintenance of their subordinate behaviour towards the more powerful medical profession (Abbott, 1988; Pratt, 2001). Respondents continued to construct this traditional identity, even when it was detrimental to their organisational influence. This encourages an occupational, vocational and subordinate ideology, perpetuates the existence of professional hierarchies within the NHS and maintains the assumption that nurses are not stereotypically appropriate leaders (Brooks, 1996; Currie et al., 2010; Hall, 2005; Jost & Elsbach, 2001; LaTendresse, 2000). However, through encouraging this conformity to subordination, they protect and maintain their professional sphere of influence through the maintenance of their strong occupational, vocational ideology, and the

internalisation and validation of existing social hierarchies and systems (Jost & Elsbach, 2001; LaTendresse, 2000).

Respondents, therefore, acted in ways to perpetuate the existing informal hierarchies in the NHS, significantly undermining their own potential organisational leadership abilities by constructing identities which were incongruent with leadership. Despite this, it emerged from interviews that a reliance on clinical team hierarchy was only detrimental to nursing leadership in comparison to medical or managerial leadership, entrenched power hierarchies that nurses generally did not attempt to challenge. The results also indicated that respondents were engaging in inter-group comparisons with other groups they perceived to be of lower status, thereby protecting their unique professional status within the organisational system.

Comparisons with Allied Health Professionals (AHPs) were the most frequently used technique. AHPs are often seen as supplementary workers in the NHS who do not enjoy as much influence or credibility amongst patients and health professionals as the traditional professions of nursing and medicine (Nembhard & Edmondson, 2006; Pond, 2006; Shortell, 1974). Whilst doctors possess great formal organisational power, nurses exert much informal power by influencing doctors and regulating access by other professions to patients in their care. Study respondents demonstrated the active perpetuation of the organisational culture and informal hierarchical structure, rather than passive acceptance of it. Whilst their actions reduced their organisational leadership potential, it maintained their professional ideology and protected their traditional sphere of influence as a key component of patient care. Ultimately this protection cemented the sense that at organisational level they are still seen as 'nurses', subordinate and passive, not conforming to implicit leadership categories and therefore not legitimate. It is interesting that nurses in this study actively encouraged and maintained this subordinate identity in order to retain their traditional inter-group influence.

9.3   How are Identity Conflicts Resolved?

Whereas the previous section converges with literature, in this section I outline new theoretical contributions to identity work in the process of identity construction. The identity conflicts identified from the data sets clearly illuminate the potential obstacles for subordinate professionals attempting to take on leadership positions. Exploring how respondents overcame these conflicts, I identified that they engaged in various types of identity work, in an attempt to resolve conflicted identities and construct new ones. Identity work is a term used to denote the process by which individuals actively construct their identities, and consequently set about communicating and portraying that identity to themselves and others (Watson, 2008, 2009). As acknowledged by Watson (2008), this is not primarily seen as an internal, self-focused process, but self-reflection and identity construction through discourse and interaction with others, to clarify whom one is and is not. In addition to conveying a desired impression to an audience, identity work allows individuals to confront and resolve feelings of anxiety and confusion about their identity (Alvesson & Willmott, 2002; Schlenker, 2003; Sveningsson & Alvesson, 2003; Tice & Wallace, 2003). Through thematic analysis of interview recordings, it became clear that all respondents in this study were engaging in identity work of some type, to resolve internal conflicts and construct a positive external image. For the purposes of this study, these processes are termed 'aggrandising', 'demonising' and 'splitting or fusing'.

9.3.1   Aggrandising

'Aggrandising' work is identified as a self-enhancement mechanism, used to increase legitimacy and a sense of self worth. In a sense, the underlying driving force behind the aggrandisement work is to establish to oneself and others that one is 'one of the goodies and not one of the baddies' (Watson, 2009). For study respondents, aggrandising work was used in two different ways depending on context and audience: aggrandising the importance of constructing and protecting traditional nursing identities; and aggrandising the need to adapt professional group identities in a non-prototypical manner, to achieve higher levels of organisational influence.

154

As identified above, the salience of their professional background meant the majority of respondents associated some sense of psychological commitment with their traditional group membership. Reflecting this, most respondents aggrandised their traditional role identity and ideology, elevating their practice to a higher moral level described as the 'nurse ethic'. They almost romanticised the altruistic, emotional connection they had through their patient contact. This was even true of those who no longer fulfilled prototypical roles, working in managerial posts with no direct patient contact. Whilst their strong occupational ideology and sense of ethical altruism could be responsible for this aggrandising behaviour (Ashforth, Kreiner, Clark, & Fugate, 2007), further exploration of aggrandising work amongst respondents demonstrated that the need to portray a sense of group membership is more related to issues of legitimacy and influence. This was evidenced by responses from nurses in managerial roles, who attempted to construct and portray a positive self-image to others by aggrandising their 'ethical' behaviour, which was in line with central nursing values (patient focused care, altruism), and not in line with managerial values, associated with budgets and bureaucratic agendas.

Whilst this aggrandising work was employed to overcome legitimacy conflicts associated with a move out of the clinical team, it was a primarily a discursive mechanism which did little to resolve the internal identity conflict associated with a sense of loss of their professional identity. This meant that whilst respondents in managerial leadership posts aggrandised their traditional identity, to influence and achieve respect from the professional nursing group, they also took on an adapted group membership. It has previously been suggested that prototypical ideals and values can be altered and adapted to enhance the presentation of a legitimate identity (Creed, Scully, & Austin, 2002). This was clearly demonstrated in this study, where nurses in positions of formal management and leadership, who no longer fulfilled traditional nursing roles, still identified themselves as nurses due to their core values and beliefs, but portrayed themselves as slightly different due to their managerial identity element. By then aggrandising their organisational leadership potential due to their formal role, they legitimised their adapted identity

155

by portraying themselves as working to support and enhance the profile of traditional nursing values.

The assertion that, despite this adapted group membership, their salient professional values remained, was reinforced by the substitution techniques employed by respondents who no longer had a clinical role. In order to overcome the conflict associated with a lack of patient care, undermining their ability to portray themselves as caring and altruistic, a number of respondents reported substituting their patients with their staff. In this way non-prototypical individuals were able to aggrandise and project the caring and nurturing side of their identity to others and to themselves, constructing a shared group identity. This finding was particularly interesting and there appears to be no existing research exploring this substitution mechanism. It clearly indicates the process by which individuals begin to change their behaviours, which are so central to their self-identification.

The adaption of their professional identity also challenges theoretical assumptions about the stability of salient professional identities. Previous research into traditional professions has found that salient professional identities are enduring, and commitment to the professional group was strong in all roles (Forbes & Hallier, 2006; Kippist & Fitzgerald, 2009; Wallace, 1995). These results illuminated the need for subordinate professions to adapt their professional identity to reduce irreconcilable conflicts, associated with the move into non-traditional work roles and a sense of dissociation from their professional group. Only by adapting their perception of the group ideology and behaviours could non-prototypical respondents maintain their psychologically important group membership, and align their new leadership roles with a sense of professional worth and intrinsic value.

Aggrandising identity work is fundamentally a process of self-enhancement. By aggrandising the importance of prototypical nursing ideologies and work, the traditional nursing identity is

protected and seen as important. It elevates the work of nurses to a higher moral level, which increases their self-esteem and subsequently reinforces their psychological commitment to the group. It engendered a sense of collegiality amongst respondents, and increased the potential influence and credibility of those in non-prototypical roles. Whilst this behaviour might be expected, the aggrandising work associated with an adapted group membership was not. This study has demonstrated that an adapted group membership was used to overcome issues associated with organisational influence, as well as an attempt to resolve a sense of loss of the core behaviours that define the nursing professional identity. By adapting and substituting nursing values into managerial roles, non-prototypical respondents were able to legitimise their role and enhance the importance of their role for the patient, traditional nursing profession and the wider organisation.

9.3.2   Demonising

The term 'demonising' is used to explain the identity work employed to undermine those who were seen as out-group members. As discussed above, aggrandising work is used to portray oneself as one of the 'goodies'. Demonising work is therefore used to identify the 'baddies', to enable favourable in-group comparisons and further increase self esteem and psychological group commitment (Crocker & Park, 2003; Dunning, 2003). People define themselves by dis-identifying with a social group: *'Defining who we are is often achieved by defining who we are not'* (Elsbach & Bhattacharya, 2001; pg 406). In this study, the demonising work was not used to undermine groups outside of the profession, but rather sub-groups within the profession, contributing to the process of on-going professional stratification (Freidson, 1988).

The need for non-traditional nurses in potential leadership roles to aggrandise and construct an adapted professional identity was problematic, as it created new sub-groups within the profession: prototypical nurses in traditional ward based roles with direct patient contact, and non-prototypical nurses in formal positions of managerial leadership with little or no direct

patient contact. Whilst existing research into out-group demonisation has focused on interactions between professional groups (Jackson & Smith, 1999; Kalkhoff & Barnum, 2000), this study clearly indicates individuals engaging in a similar undermining *within* the profession.

Prototypical nurses used demonising mechanisms to draw comparisons with the importance of their traditional professional role and identity. In interview discourse they portrayed non-prototypical nurses as lacking understanding, selling out and unable to handle the physical and emotionally draining demands of the traditional nursing role. This demonising work subsequently reinforced and enhanced the importance of the traditional ideology, by undermining and discrediting those with non-prototypical identities. In doing so, the need to retain a prototypical identity within a culture which discourages leadership and ambition (Dingwall et al., 1993; Kreuger, 1978; Mackay, 1989; Whittaker & Olesen, 1978) was reinforced. Working to protect the prototypical nursing ideal once again reduced the potential of the construction of a legitimate leadership identity, subsequently undermining the professional leadership contribution.

Non-prototypical nurses also engaged in demonising work to legitimise their move into managerial, non-traditional identities. The results illuminate portrayals of prototypical nurses as lazy and uncaring, the antithesis of the nursing ideal. Used in conjunction with their aggrandising work towards their adapted group membership, this group of respondents attempted to portray themselves as attempting to 'save' or 'lead' nursing by constructing a different identity to aspire to. Through this identity work they began to overcome conflicts related to a loss of professional identity, they portrayed themselves as in fact protecting the core elements of that identity.

For this subordinate professional group these processes were detrimental, as they resulted in horizontal violence (Apesoa-Varano, 2007; McKenna, Smith, Poole, & Coverdale, 2003), a term relating to high levels of interpersonal conflict within a profession, and prevented cohesive group action. Demonising identity work was therefore not used to undermine other professions,

158

enhancing the status of the profession as a whole, but within the profession, causing in fighting and a lack of group cohesiveness. Oppressive identity work has previously been identified as undermining and devaluing less powerful groups so they are unable to construct credible, or legitimate identities (Schwalbe & Mason-Schrock, 1996). In the context of this study, the oppressive identity work uncovered is illuminating in exploring the reasons behind the negative group culture often associated with low-status, subordinate groups (Apesoa-Varano, 2007; Chan, 2002; Jost & Elsbach, 2001). The demonising work is consciously used to draw out-group comparisons to stabilise and enhance in-group identities. In reality it only contributes to the fragility and uncertainty of nursing leadership identities and compounds the problems leaders face in attempting to retain credibility with both subgroups, as oppressive identity work inhibits the construction of a credible identity.

9.3.3   Splitting and Fusing

Aggrandising and demonising identity work were used as mechanisms which enabled the construction of different identities through social interaction with different audiences. By aggrandising in-group membership and demonising out-group behaviours, individuals attempted to legitimise their roles and behaviours to others and themselves. Problematically, this identity work alone did not resolve the internal conflict encountered by potential leaders. It was primarily aimed at gaining external influence, and acceptance by others, using different types of narrative identity work to construct and portray a desired identity. When addressing the question of how respondents dealt with the difficulties of constructing and presenting two identities, which could be seen as paradoxical (managerial and professional), the results indicated a third type of identity work: splitting and fusing.

Splitting took two forms: splitting and then rejecting one aspect of a conflicted identity, or splitting and constructing salience hierarchies. The term 'rejection' is used to denote a process by which an individual cognitively rejects a potential identity, which may threaten their salient self-identity.

159

Similar to the idea of 'deletion', which was examined at an organisational level by Pratt & Foreman (2000), rejection rids the individual of one of their conflicted identities to reduce internal turmoil. Subsequently, individuals classify themselves (within the work environment) as belonging to a singular professional group, personifying one salient identity. Total 'rejection' is a rare occurrence, as it is difficult to cognitively cease association with an identity which is an important aspect of self or role. The most common type of identity work demonstrated in results was the situational splitting of identities.

By situationally 'splitting' their identities, individuals were able to compartmentalise different aspects of themselves, creating salience hierarchies. Compartmentalisation allows an individual to embody separate identities with distinct values and behavioural expectations, without combining them to reduce identity conflict (Kreiner et al., 2006; Pratt & Foreman, 2000). The results indicated numerous occurrences of this type of identity work. The acknowledgement of 'ring fencing' which allowed conflicted individuals to construct two separate identities, enabled them to evoke different behaviours and priorities in different situations, thereby projecting to others contingently different identities through different mechanisms of narrative identity work. This was clear in responses from individuals who attempted to increase their legitimacy among different audiences by constructing different identities. For example, when attempting to influence prototypical nurses, they would engage in identity work which would highlight their professional background and present themselves in a way which conformed to group prototypical expectations, but when attempting to influence stronger professions, such as medical staff, they would construct the image of a prototypical hierarchical manager and behave accordingly.

The final identity work process used is labelled 'fusing' whereby individuals retain multiple identities within a single persona, but do not split them. By fusing their different identities they construct a hybrid whole, a new type of identity which reflects elements of all their different group memberships (Pratt & Foreman, 2000). Constructing a new hybrid identity allowed individuals to endow both aspects of themselves (professional and managerial) with the same levels of

importance. As such, respondents who engaged in fusing work acknowledged the explicit use of their professional ideology to guide their managerial behaviour, whilst not allowing it to overwhelm and take priority over their managerial identity, which was seen as equally influential in decisions. This 'layering' of identities has been noted as the way in which successful medical professionals move from a clinical to managerial role. New identities do not replace old ones but are layered on top of one another (Iedema et al., 2004). In this way individuals achieving a hybrid position should theoretically enjoy low levels of conflict as their previously paradoxical identities now lie harmoniously within a newly constructed identity.

9.3.4 Leadership Development

Day & Harrison (2007) argue that career transitions require changes in leadership identities, which can be mediated with facilitated leadership development. At different stages of identity transition, different types of support are needed. For novice leaders, focus needs to be placed on their ability to achieve acceptance from within the team they are attempting to lead, often relating to their prototypical nature (Hogg, 2001). As individuals move into more formal, demanding managerial positions they need to be able to integrate all the values and aspects of their identities to construct a stable, salient leadership identity (Lord & Hall, 2005). Leadership development programmes are crucial in this process.

Leadership development programmes can be conceptualised as organisational mechanisms which mediate the conflicts encountered by individuals during identity transitions (Carroll & Levy, 2010). In this way, organisations have the potential to create a theoretical space in which individuals are encouraged to address their current leadership identities and begin the process of developing them into more salient identities. In this study, although a few respondents commented on the leadership development programmes as spaces to address their leadership identity, the majority reported a rather more negative experience. They viewed the programmes as systems of organisational control, whereby the NHS organisation could 'convert' employees to

get them to conform to organisational priorities and expectations. This rather limited influence on participants' identity constructions was reflected through the findings that there were no changes in salient identity constructions over the course of the study. One year after attending the leadership development programmes, all respondents were experiencing the same identity conflicts, engaging in the same narrative identity work, and constructing the same identity types. From these findings, it can only be concluded that, at least on this occasion, the NHS leadership development approach only acted as a mechanism of organisational control.

Conceptualising leadership development programmes as a mechanism of organisational control has been demonstrated in previous research (Alvesson & Willmott, 2002). This suggests that organisations can shape and encourage certain identities to develop, consequently producing 'appropriate' leaders, conforming to leadership identity schemas as well as organisational visions. Problematically, in this case, the issues of incongruence between nurses' professional identities and the 'appropriate' leadership behaviours were not tackled by the development programmes. As such, they were seen as relatively unsuccessful by most respondents, who had to engage in individualistic, narrative identity work processes to address identity conflicts. This outcome seems to reflect work conducted by McGivern & Ferlie (2007), suggesting that entrenched professional practices cannot be altered through conformity to 'tick box games'. A skills or competency based approach may, on the surface, appear to engender professional conformity, whilst in reality they will continue to act in traditional ways. For the nursing profession, this means perpetuating constructions of prototypical ideals which cause intrinsic conflicts for those in managerial roles. In the conclusions chapter, I offer recommendations on how to improve leadership development programmes in the NHS.

9.4   Constructing Identities

The outcomes of identity work are two-fold. First, they portray and communicate a desired image to others through in-group favouritism and out-group comparisons, communicated through social

interactions. Secondly, they facilitate the internalisation of these outward presentations to construct an individual's identity (Beech, 2008). These identity constructions need to fulfil basic psychological needs, such as a sense of belonging to social group associated with self worth, in order for the individual to feel a sense of resolution and contentment with their internalised identity (Ryan & Deci, 2003). Previous studies into identity constructions within the nursing profession are limited, but one smaller study suggested three types of nursing identity: clinician, manager and hybrid (SØRensen et al., 2011). Whilst the identity of 'clinician' and 'manager' are reflected in results, the taxonomy suggested by Sorensen et al (2011) is too simplistic, as it does not consider the complexities of the 'hybrid' identity. I have clearly demonstrated a distinction between two hybrid identities: the split and fused hybrid.

Table 9 gives a break down on the demographics of the four identity types, by gender and by role type.

Table 9 – Demographics of Identity Constructions

	Clinician	Manager	Split Hybrid	Fused Hybrid
Total Number	**7**	**3**	**14**	**8**
Female	5	3	12	4
Male	2	0	2	4
Role Type:				
Clinical	7			
Mixed			13	1
Managerial		3	1	7

The table clearly indicates a correspondence between job role and identity construction. Clinicians were only found in clinical roles, managers only in managerial ones, split hybrids primarily in mixed-roles which required clinical and managerial elements, and finally split hybrids primarily in managerial roles. Whilst the sample size of female respondents was higher than male, as to be expected given the gender-based profession, it is interesting to note that in the 'fused hybrid'

category half the respondents were male. Additionally, the only fused hybrid in a mixed job role was also male. This disproportionate representation is interesting and, whilst this study is not concerned with gender politics, further research may be required to explore the implications and conclusions which may be drawn from this. I will now discuss the identity work used to construct each identity, and the resulting impact on internal conflict and potential leadership influence.

9.4.1   Clinicians and Managers

'Clinician' is the term used to identify the group of respondents who actively rejected the potential of a managerial identity, and constructed a singular salient identity of 'Nurse'. As demonstrated in Table 9, these respondents only held traditional, patient care roles, which enabled them to display prototypical nursing behaviours congruent with their professional identity, and were clear about their conscious decision to reject a managerial identity to protect their prototypical identity. They used limited aggrandising work, probably as their roles were prototypical and demonstrated their salient professional identity, and primarily engaged in demonising work through social interactions to legitimise their rejection of a managerial identity element. Viewing anyone other than prototypical nurses as the out-group, they employed demonising work to draw comparisons with these groups, whose actions were deemed morally lower than the Clinicians', due to their association with managerial demands.

Due to a reluctance to deviate from the portrayal of a prototypical nurse, this group remained passive and subordinate to stronger professions and made no attempt to lead or influence others, surrendering themselves to the social stereotypes held about their profession. Whilst they were willing to enact informal, professional leadership, this was only the case when they could align their actions with their salient professional identity. The one-dimensional nature of the 'clinician' identity meant they were only able to employ informal, professional leadership related to their prototypicality. They did not enjoy any organisational leadership, and perpetuated the difficulties previously acknowledged with nursing leadership (Dingwall et al., 1993; Kreuger, 1978; Mackay, 1989; Whittaker & Olesen, 1978).

164

A small number of respondents took the unusual step of rejecting their professional identity in favour of a managerial identity. These respondents were labelled 'Managers'. These individuals reported feelings of frustration due to the constraints associated with their passive, professional identity. As a result they rejected their professional identity, and constructed a singular managerial salient identity, in which they rejected all association with their professional background. They used excessive demonising work to make it clear they had no allegiance with the professional clinical group, in a process defined by Sveningsson & Alvesson (2003) as anti-identity metaphors: defining who you are by who you are not. Managers seemed so keen to dis-identify themselves from the nursing group that they engaged in repeated undermining of prototypical nurses, depicting them as incompetent, uncaring and selfish – the antithesis of the prototypical nurse image. By demonising all members of the nursing profession, 'Managers' were able to legitimise their conscious rejection of a professional identity.

Identity constructions of 'Manager' and 'Clinician' were the least frequently constructed identity types amongst respondents. It is difficult for people to reject outright an identity, which was once a crucial aspect of self, to create a 'Manager' identity. From these findings, it could be suggested that those individuals who became 'managers' never fully identified with their nursing professional identity, and did not associate a sense of personal worth with their professional group membership. Rejecting a managerial identity outright to be a singularly salient 'Clinician' is increasingly difficult for prototypical nurses to do, as their roles become increasingly managerial. Respondents who managed it in this study were in clinical-only roles and were therefore afforded that ability.

These identities could be seen as remnants of an archaic NHS, in which individuals see themselves as either managers or clinicians, and are unable to bring the two roles together. These identity constructions are at odds with current policies advocating the need for increased numbers of

organisational managers with clinical backgrounds, as well as the need for clinicians in traditional job roles to take on more elements of managerial elements (Darzi, 2008; DOH, 2010). The results illuminate further the need for these joined-up roles to be developed. 'Clinician' respondents struggled to exert more than informal, professional leadership, and were not seen as effective organisational leaders, due to their conformity to a passive prototype, incongruent with managerial leadership behaviours. 'Managers' may have distanced themselves from this passive, undermined role, but in so doing reduced any influence or legitimacy they previously held with the professional group, reflecting the lack of credibility of so-called 'general managers' amongst professionals in the National Health Service, which is widely acknowledged (Currie & Suhomlinova, 2006; Hoque et al., 2004; Klein, 2001; McNulty, 2003). By consciously eradicating one potential identity in favour of another, individuals limited exposure to internal conflict, as they conformed to only one identity schema. These respondents were in the minority and had made a decision to remain purely clinical, or disassociate themselves from their professional background to become purely a manager. The lack of competing ideologies reduced their internal conflict, but their one-dimensional character reduced their levels of influence and perceived legitimacy.

9.4.2   Split Hybrids

The majority of study respondents held job roles requiring them to fulfil at least some degree of managerial responsibility. Unlike individuals who could construct a singular identity such as clinician, these respondents (with the exception of one individual) held dual managerial and clinical roles. Many used identity work to split and compartmentalise their managerial and clinical identities, in order to deal with paradoxical identity and role conflicts. This group is termed 'Split Hybrids', individuals who construct different identities in different contexts, actively associating with or distancing from conflicted aspects of their identities in social interactions in different situations. Split hybrid roles were particularly associated with those in non-traditional, middle management roles, such as clinical managers. They were not able to reject one element of their identity so had to embody them both.

The splitting work employed by split hybrids was used to try and balance both elements of their managerial clinical roles, by constructing different identities in different situations through social interactions with others. By aggrandising their traditional, professional background and associated values, whilst also demonising nurses in non-prototypical roles, split hybrids could attempt to gain influence and collegiality with prototypical, clinical nurses, constructing a shared identity. In addition, this attempt to aggrandise traditional group membership is a reflection of their desire to protect their professional identity. Paradoxically, split hybrids also used demonising work to undermine prototypical nurses and aggrandise the need for a managerial identity. This identity work was used to distance themselves from the professional group, in order to achieve more influence during social interactions with more powerful groups such as doctors and managers.

The identity work mechanisms used varied, depending on the audience and context, or on the type of image they were trying to construct at any one time. When individuals feel they need to prove their legitimacy they may attempt to demonstrate they can live up to the positive expectations of their identity groups (Roberts, 2005). In this situation, the identity work used was often contradictory, illuminating the struggle of split hybrids to resolve the incongruence between a managerial leadership role, and their historical nursing ideology, which is strongly intertwined with their personal identity. As a result, these individuals encountered high levels of conflict, as they compartmentalised identities, a mechanism which results in a failure to integrate values and attitudes of both roles (Ashforth & Mael, 1989). As such, respondents felt unsatisfied as they attempted to construct two distinct, non-integrated identities, resulting in large amounts of identity conflict. Splitting their identities in this way was an attempt to achieve influence with a diverse audience, but in reality it undermined their influence, as they were seen as trying to be all things to all people, displaying contradictory and hypocritical behaviors in their interactions with different groups. As a result, Split Hybrids reported high levels of unresolved identity conflict. Their roles required them to adopt managerial values, and their self-identity was so closely linked

with their professional membership, they struggled to align the two. Many respondents reported a sense of low job satisfaction and low self esteem related to the incongruence between their job role and their self-identity (Ryan & Deci, 2003).

As previously acknowledged, all respondents constructing a Split Hybrid identity held jobs which could be classed as 'middle management' positions (Currie, 2006). Research into middle managers in other professions also highlights the uncertainty and fragility of their identity constructions, resulting in a sensation of 'losing the plot' (Thomas & Linstead, 2002). Their role ambiguity, combined with multiple, conflicting demands from up and down the organisational hierarchy, means that constructing a stable identity is almost impossible for these individuals. As a result Split Hybrids appear to be constructing 'provisional selves' (Ibarra, 1999), identities which are constantly shifting between their new, conflicted role and their current capacity and self conception. In another sense, these individuals are caught in a liminal space.

Liminality refers to the temporary state which occurs during transition from one identity to another (Beech, 2011). Responding to a recognisable trigger or event, in this case the move into a managerial leadership role from a professional or clinical one, individuals move into a position where they can embody paradoxical identities (Beech, 2011). In this case, split hybrids were members of the profession and yet not members of the profession, managers and yet not managers. In addition to the psychological liminal spaces, these individuals found themselves physically located in a liminal hierarchical position. Middle managers often find themselves attempting to temper the gap between subordinates and their superiors, trying to influence a number of audiences, with conflicting demands and expectations (Ainsworth, Grant, & Iedema, 2009; Sims, 2003). This explains the need for split hybrids to employ contradictory identity work processes, simultaneously associating with and distancing from professional groups. Attempting to portray a situational identity to multiple groups is uncomfortable for individuals, calling into question their true identity and legitimacy, both from themselves and others. Employing

compartmentalisation work reinforces contradictory identities, reinforcing the identity conflicts faced by these individuals (Schlenker, 2003; Sveningsson & Alvesson, 2003).

Whilst liminal identities are often assumed to be transient (Garsten, 1999) some split hybrids in this study had remained in their conflicted state for many years. Somehow they had managed to stabilise a theoretically unstable identity, which allowed them to function adequately. Clarke, Brown, & Hailey (2009) suggest diverse and contrasting identity demands can become so intense they are forcefully incorporated into the self, resulting in stable but non-coherent identities. Split hybrids will continue to employ antagonistic legitimising strategies, allowing them to function adequately. The perpetuation of their liminal identity, theoretically should allow split hybrids to move between different organisational groups, evoking different constructions of identity depending on their audience, which could allow for increased creativity and influence among different groups (Ellis & Ybema, 2010; Sturdy, Schwarz, & Spicer, 2006).

In reality, the split hybrids did not find their liminal identities a positive asset. Whilst many had competently functioned in their roles for years, they still faced an internal conflict about their role and identity, as well as an undermined leadership potential. Their liminal, fluid identity meant that they were not seen as 'in-group champions' (Haslam, Reicher, & Platow, 2011; pg. 109). Although they employed identity work to aggrandise their professional group membership, this was not reflected back by Clinicians constructing a prototypical identity. This lack of affirmation from others meant that split hybrids could not construct a legitimate leadership identity (DeRue & Ashford, 2010). They encountered the same problem when trying to portray an image of an organisationally influential managerial leader. Their inability to conform to implicit leadership theories, due to their continuing association with their professional background, means that they will not be affirmed as leaders within the wider organisational system (DeRue & Ashford, 2010). This reflects findings from previous work about conflicted middle managers, where conflicted individuals will unintentionally construct and enforce identity fragmentation through their narrative identity work, due to a commitment to an identity narrative incongruent with the reality

of role demands (Svenningson & Alvesson, 2003). For nurses, the reluctance to let go of their traditional identity construction, which is tied up with their personal identity, has a dramatic influence on their ability to construct a leadership identity. It is at the boundary where nurses must negotiate between the 'me' of their personal identity, and the 'we' of their expected identity related to professional role, where respondents appeared to encounter the most problems (Kreiner & Sheep, 2006).

Split hybrids therefore occupy a liminal space as they attempt to mediate the disconnect between the 'me' and 'we' of their identities. Instead of using this space to cross boundaries effectively, they find their leadership influence limited across all contexts, and experience high levels of internal conflict as they attempt to construct and embody two separate and conflicting identities. Whilst these results demonstrate the transition of some respondents into a more stable identity construct, many will never resolve the issues associated with a split hybrid construction, as they are too entrenched and the nature of the identity demands are too intense. This group make up the largest number of respondents and make a clear statement about the ineffectiveness of nursing leadership.

9.4.3   Fused Hybrids

Whilst the difficulties associated with the embodiment of two separated identities were clearly demonstrated by split hybrids, another group of individuals were identified, who had been able to fuse their managerial role and identity with their professional background; 'Fused Hybrids'. By fusing their managerial and professional identities, they constructed a whole new identity, which afforded both identity aspects the same level of importance. As such, their professional and managerial identities were used equally to influence behaviour and guide actions. They aggrandised their adapted group membership (including substituting caring for patients with caring for staff), allowing them to retain a sense of prototypical nursing values and ideals within the context of a managerial role and identity. Aggrandising this adapted membership and new

identity meant they were acknowledged by prototypical nurses as managerial figures, whose sense of nursing values was strong. By not attempting to assume the same identity as prototypical nurses, and by acknowledging and aggrandising the important distinctions in their new role, they attained respect and influence among the prototypical nursing group. Fused Hybrids acknowledged the non-prototypical nature of their roles, but aggrandised the importance of their professional background. As such, they constructed an adapted group membership, behaving in a non-prototypical manner in their day-to-day role, but being seen to adhere to the central values and beliefs of the professional group. By maintaining both roles they were not seen as totally detached from prototypical group members, and their retention of nursing values and explicit allegiance with the profession allowed them to enact professional leadership, as they were seen as role models. The lack of demonising techniques shows that they are not trying to undermine other groups to achieve legitimacy, they are not portraying different images to different people through social interactions. Rather, their narrative identity work was always attempting to construct the same, stable identity, regardless of audience.

By balancing their adapted professional group membership with their managerial identity, they were also seen as effective managerial leaders, enjoying influence within the wider organisational system. The fused hybrid construction would therefore seem to be the optimal identity type for nursing leadership. Research into medical leadership typologies have also identified the hybrid clinician-manager as the optimal identity outcome, and have explored the way in which these medical leaders are able to work across boundaries, creating a new identity and professional jurisdiction (Llewellyn, 2001). The key element of this identity construction is the refusal to give salience to one identity over, so they can successfully cross organisational boundaries and achieve widespread influence amongst managers and clinicians alike (Diefenbach & Sillince, 2011; Iedema et al., 2004). However, the studies investigating doctors do not take into account the assumptions of their pre-existing organisational influence, and the importance of maintenance of clinical work alongside a leadership role to retain legitimacy and collegiality amongst professional colleagues (Witman et al., 2011). Nurses do not enjoy the same levels of influence and respect within the

informal professional hierarchies in the NHS, and the existence of hybrid medical managers within the organisational hierarchy further enhances the dominance of the medical profession (Dingwall et al., 1993; Kreuger, 1978; Mackay, 1989; Whittaker & Olesen, 1978; Witman et al., 2011).

It is worth noting that the individuals who successfully constructed a fused hybrid identity, which was influential in all contexts, were in high organisational positions, where they were afforded formal power and status. This is shown in Table 9, which highlights that all fused hybrids, with the exception of one, were in managerial roles. It may be that only when subordinate professionals are in superordinate job roles that they are able to personify both roles without risk of being undermined. Doctors are able to retain legitimacy due to their professional background, for nurses it may be a case of achieving legitimacy *in spite* of their professional background. Once in these positions of authority, fused hybrids are able to re-embrace their nursing membership, safe in the knowledge of their formal role. This is reflected by the higher hierarchical roles of fused hybrids and the middle management roles of split hybrids (Table 9).

At this level of identity construction, the transition of salient identity from professional nurse to strategic leader is complete. Fused hybrids reported relatively low levels of internal conflict, as they could balance their professional background with their leadership role. Additionally, their explicitness about the importance of both their roles afforded them legitimacy as formal managerial leaders, as well as informal professional leadership and influence. Fused hybrids are the 'gold standard' of what effective nursing leadership development is attempting to achieve, and represent an elite strata of nursing (Freidson, 1988). The formal, hierarchical power which is required to successfully develop and construct this identity, and overcome the social stigma associated with their professional background, is problematic as it requires nurses to move totally away from their professional, clinical role. Whilst doctors can combine clinical and managerial work, at this level only one fused hybrids in this study occupied dual roles. How the transition between split and fused hybrid occurs is unclear and requires further exploration. To attribute it

172

entirely to macro role transitioning may be oversimplifying the matter, it is likely there are other factors at play.

9.4.4   A Process Model of Identity Transitions

Figure 1 summarises the identity development process, from prototypical group member to strategic organisational leader, highlighting the macro-role transitions, previously identified as identity work triggers (Ibarra & Barbulescu, 2010). These transitions force identity change, with identity work processes used to reduce conflict, increase feelings of authenticity and ultimately construct a new, more stable identity.
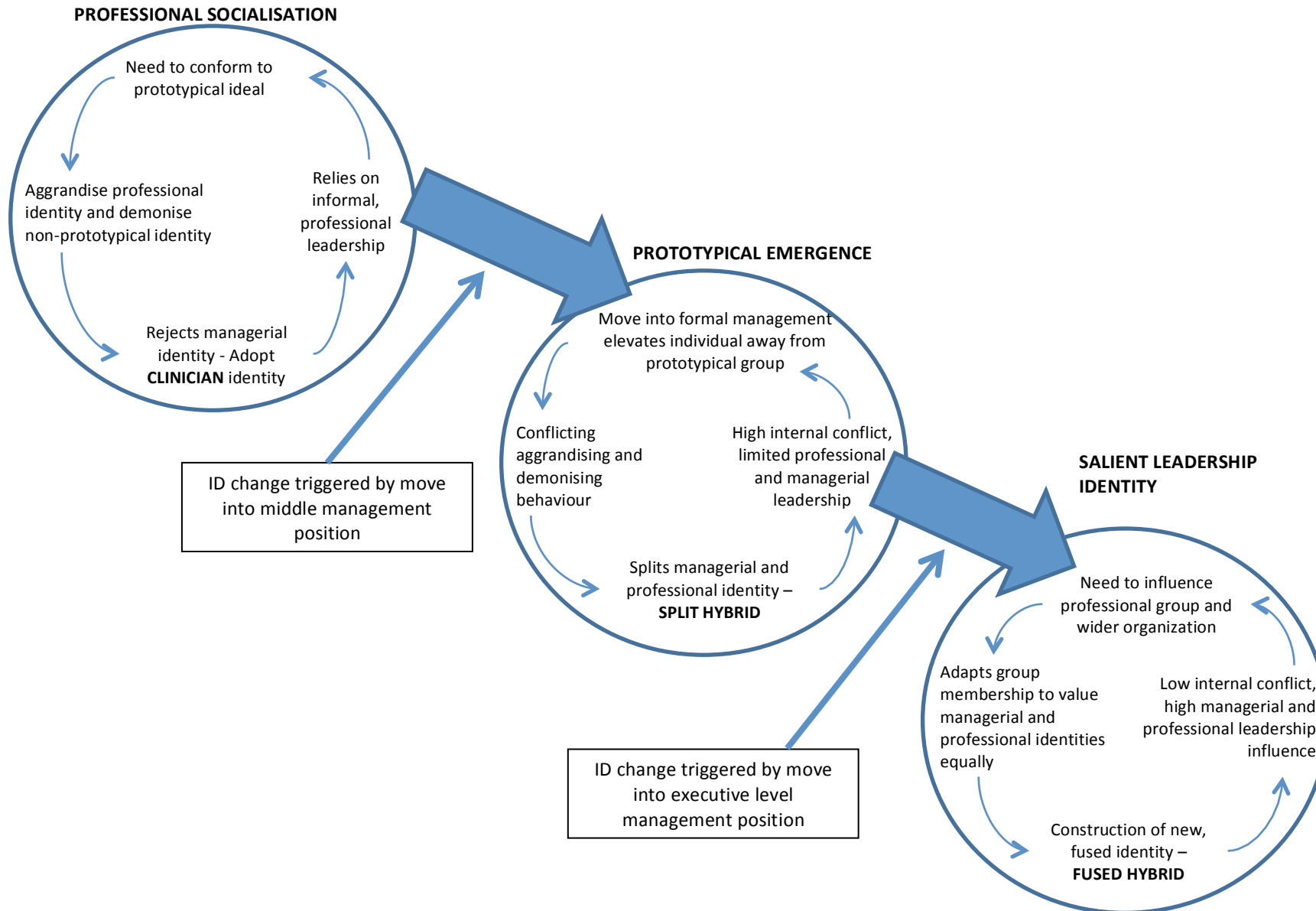
The process begins with all professionals undergoing professional socialisation events, encouraging individuals to conform to group prototypes to achieve social influence. At this stage individuals engage in narrative identity work to construct and maintain a 'clinician' identity, relying on their prototypical, informal, and professional influence to enact leadership. They use demonising work to highlight the incongruent behaviour of non-prototypical nurses, enhancing their own prototypical nature. Paradoxically, due to their high levels of informal group influence and representativeness, many of these individuals will be promoted into more formal, middle-management roles.

This role transition elevates prototypical individuals away from their social group membership, requiring them to act in non-prototypical ways, and triggering feelings of identity conflict. These feelings of conflict are apparent when individuals engage in contradictory identity work. They often simultaneously aggrandise their professional background whilst demonising prototypical nurses, and demonise those in managerial positions similar to their own whilst aggrandising the importance of their own role. In addition to this contradictory work, salience hierarchies are constructed by splitting conflicted managerial and professional identities in an unsuccessful attempt to overcome conflicts. This constructs a 'split hybrid' identity, characterised by

173

individuals who attempt to personify different aspects of themselves in different situations, engaging in contradictory social interactions depending on audience, resulting in highly conflicted, poorly influential individuals.

The highly unsatisfactory phase of the 'split hybrid' identity transition will continue until individuals are able to internalise a more stable, satisfactory identity (Ibarra & Barbulescu, 2010). Figure 1 shows that this only fully occurs with a role-transitioning event, moving split hybrids from conflicted middle management positions into non-clinical, executive level posts. At this stage they have enough formal, managerial influence to fuse their professional and managerial identities, without risking being undermined due to their professional background (this is not necessarily the only factor involved in this identity transition, but for the purposes of this study it was clearly one of the most important elements). These individuals are able to afford both aspects of their identities with equal salience, constructing 'fused hybrid' identities. They are characterised by a new, adapted professional identity which values the importance of their managerial work as equal to their professional values. These fused hybrids enjoy influential professional and managerial leadership within the context of their stable identities, due to the fused nature of their role. Unfortunately, very few respondents achieve this final transition, and the majority will remain in the cyclical transitioning phase of split hybrids.

Figure 1: A Process Model of Identity Transitions

PROFESSIONAL SOCIALISATION

Need to conform to prototypical ideal

Aggrandise professional identity and demonise non-prototypical identity

Relies on informal, professional leadership

Rejects managerial identity - Adopt **CLINICIAN** identity

ID change triggered by move into middle management position

PROTOTYPICAL EMERGENCE

Move into formal management elevates individual away from prototypical group

Conflicting aggrandising and demonising behaviour

High internal conflict, limited professional and managerial leadership

Splits managerial and professional identity – **SPLIT HYBRID**

ID change triggered by move into executive level management position

SALIENT LEADERSHIP IDENTITY

Need to influence professional group and wider organization

Adapts group membership to value managerial and professional identities equally

Low internal conflict, high managerial and professional leadership influence

Construction of new, fused identity – **FUSED HYBRID**

9.5   Conclusion

In this study I have illuminated three different aspects associated with the construction of a leadership identity amongst subordinate professionals. First, I outlined the areas of identity conflict, identifying intra and inter-group areas of potential conflict for individuals. Next, three types of identity work were explored, used to overcome these conflicts: aggrandising; demonising; splitting and fusing. The discussion outlined an increased understanding of the way in which professional identity can be adapted to create sub-groups within a profession, causing professional in-group fighting, a characteristic of subordinate professions that has been poorly explained in existing research. The way in which the perpetuation of a prototypical, professional identity can be detrimental, rather than beneficial for subordinate groups, was also explored. Finally, four different identity constructs, resulting from the identity work processes, were presented. The idea of 'hybrid' professionals was developed by determining between split and fused hybrids, with split hybrids seen as liminal bodies, giving an increased sense of understanding about the nature of the identity conflict they endure.

It is important to acknowledge these identities are not solid and fixed, they may be transient and can develop over time, as outlined in Figure 1. In a sense, the results of this study can be seen as a representation of the temporal development of nursing leadership identities within the NHS over time. The 'Clinician' and 'Manager' identities were relatively rare amongst respondents, reflecting a time in the organisational history where managers and nurses were separated by clear role boundaries. The modern NHS structure no longer supports these one-dimensional identity types, due to the proliferation of clinicians into middle-management positions. 'Split Hybrids' give a good indication about the current state of nursing leadership: confused and occupying a liminal space. This is the identity constructed by the majority of respondents, reflecting the current state of subordinate professional leadership in the NHS, due to the dual demands placed on professionals. The 'Fused Hybrid' identity is the ideal, and the construction which current policy is advocating as crucial for the future of an effective NHS. Developing this identity was difficult

for respondents, but it was possible. The next, and final, chapter considers these findings in the context of practice, theory and policy development, and illuminates how these results are crucial for the future leadership development of professional groups.

10 Conclusions and Implications

10.1 Introduction

This thesis set out to answer the question 'How does professional identity influence the ability of individuals to construct leadership identities, when those identities may be incongruent?' To address this question I examined three sub-components in respective empirical chapters:

    i)   What were the identity conflicts encountered?

    ii)   How were they resolved?

    iii)   What were the resulting identity constructions?

The results of the study in relation to these questions were discussed in the previous chapter. There, I explored how the identity conflicts encountered were due to an incongruence between a prototypical nursing identity and expected leadership behaviours. Potential leaders need to act in a prototypical manner to emerge as group leaders, but were placed at a disadvantage as they were not seen as legitimate leaders within the organisation due to their professional background. Problematically, individuals also found themselves distanced from their professional group due to their emergence into leadership roles, perceived as incongruent behaviour. To resolve these issues, individuals engaged in three types of narrative identity work: aggrandising, demonising, and the creation of salience hierarchies through splitting or fusing. This work was used differently by groups of respondents, resulting in the creation of four identity types: clinician, manager, split hybrid or fused hybrid. In the discussion I explored these identity types, and examined the resulting leadership potential of the constructions.

In this final chapter I consider the study findings in the context of existing theory, outlining my contribution to the research gaps identified in the literature review. I develop existing knowledge about leadership when viewed through the lens of identity as a socially constructed phenomenon, as well as illuminating new elements of social identity such as group identity adaptation and value substitution, which have not been explored before. These contributions and

178

development of identity theory are subsequently used to guide implications for future policy and wider professional practice in the NHS, as well as considering the generalisability of findings to other professions and organisational contexts. Finally, the limitations of the study are discussed and further avenues for research are suggested. To conclude the thesis, I offer a reflective piece exploring my own identity transitions experienced over the course of the study.

10.2 Theoretical Contributions

In the literature review I concluded that modern, pluralistic organisations could no longer rely on traditional models of leadership, instead requiring a more emergent and dynamic approach, such as the theory of Distributed Leadership, which encourages emergent, informal leadership at all hierarchical levels (Denis, 2007; Pearce, 2007; Marion, 2001; Mintzberg, 1998). In this way, organisations could encourage the development of networks, innovation and increased organisational commitment (Day et al., 2004; Gronn, 2002). Despite the potential benefits of this type of leadership, existing research into the enactment of distributed leadership relied on two key assumptions: first, that emergent leadership is dependent on a strong collective identity and supportive team (Carson, 2007; Gronn, 2002); and secondly, that the formal leadership hierarchy will support informal leaders, moving the organisation towards a flatter, network based structure rather than a hierarchical one (Day, 2006; Carson, 2007). This thesis challenges these assumptions.

The theoretical basis of the thesis focuses on the conceptualisation of leadership as a phenomenon which is constructed through interactions with others, through discursive mechanisms and narratives in an ongoing process of self-reflection, adaption and construction, shaped by social interaction (Goffman, 1959; Lindgren & Wahlin, 2001; Wells, 2007; Schwalbe & Mason, 1996). These social interactions take place within social structures, such as organisations, which act as discursive spaces in which identities are constructed to enable individuals to make sense of their collective group identifications and roles (Brown, 2006; Ibarra

& Barbulescu, 2010). Identity construction is achieved through narrative identity work, a group process by which individuals actively construct their identities, and consequently set about communicating and portraying that identity to themselves and others (Brown, 2006; Ibarra & Barbulescu, 2010; Pratt & Rafaelli, 1997; Schwalbe & Mason-Schrock, 1996; Watson, 2008, 2009). Individuals may simultaneously tell different stories to each other, enabling flexible presentations of the self, which enables participation and influence in social groups (Brown, 2006; Creed et al, 2002; Goffman, 1959).

Developing this understanding, the influence of group identity on leader emergence was examined using the Social Identity Approach (Haslam, 2004), focusing particularly on issues of identity associated with distributed leadership in a subordinate profession. Using the approach, the emergence of group leaders was linked to their representativeness of collective ideals and values, emphasising the importance of prototypical and collective identities as antecedents of distributed leadership (Hogg, 2001b; Platow, 2001). Previous research into leader emergence has assumed the existence of a group identity is always beneficial and complementary to leadership behaviours. This study was based on the argument that group identity may, at times, be detrimental to leadership emergence and effective leadership influence. This problem was illuminated by considering the disconnect between prototypical nursing identities and expected leadership behaviours, and the problems encountered by individuals attempting to construct a leadership identity, incongruent with their salient professional identity. This study therefore highlighted an arena where the antecedents of distributed leadership, such as a strong collective identity, can be detrimental to the construction of a leadership identity.

The second assumption of the theory of distributed leadership is that emergent, informal leadership will transform organisations into flat, network-based structures, in a process facilitated by formal, hierarchical leaders. In this thesis I challenged this assumption in the context of a subordinate profession, and explored how respondents in both informal and formal leadership positions still struggled at times to enact influential leadership within the wider

180

organisation, due to the existing, historical professional and managerial hierarchies. These organisational barriers are entrenched in the culture of the NHS and continue to have a definitive impact on the way in which organisational change and leadership occurs. The results suggest that the identity constructions which define social groups within organisational structures are difficult to change, and will influence the enactment of distributed leadership. This resonates with previous theoretical assumptions suggesting that identity constructions are influenced by social context, and that at times the organisational context will control and mediate the construction of identities to enhance organisational control (Alvesson & Willmott, 2002; Ibarra, 1999; Svenningson & Alvesson, 2003).

An exploration into the impact of professional group identity on leadership emergence and influence also offers interesting contributions to theories concerned with Social Identity. Using a highly salient professional group, whose core identity and sphere of professional influence is bound up with subordinance to a more powerful profession, provided new insights into the identity work processes used by individuals in identity conflict. The results illuminated how conflicted individuals attempted to resolve their identities through three types of identity work: aggrandising, demonising, and splitting or fusing. Aggrandising work highlighted the salience of the professional group for respondents, and outlined the ways in which nurses often used their leadership (informal and formal) to perpetuate the status quo of these professional hierarchies, in order to protect their unique professional sphere of influence and legitimise the core ideals of their professional identities. For these respondents, paradoxically, the salience of their professional group membership is so strong, some acted in ways to undermine their organisational leadership influence, to ensure the protection and perpetuation of the group prototype.

The findings relating to aggrandising work also illuminated new insights into the adaptation of salient professional identities, and the substitution of core identity elements and roles in the process of this adaptation, demonstrated through the substitution of patient care for staff care.

181

These insights question existing knowledge about salient identities, which were previously assumed to be relatively fixed and strongly linked to individual sense of self (Ashforth & Johnson, 2001). The aggrandising work, including the process of adaption and substitution, begins to explain how salient identities can be changed and moulded in a way which reduces identity conflict, otherwise resulting in the loss of group membership. However, although the adaption of a group identity could decrease internal identity conflict, it encouraged the formation of subgroups within the profession, resulting in out-group behaviour within the group. This behaviour has not been widely acknowledged within the identity literature, which tends to assume out-group demonization, or oppressive identity work, occurs inter-group rather than intra-group (Hogg, 2001b; Jackson & Smith, 1999; Kalkhoff & Barnum, 2000). Whilst low-status groups have previously been acknowledged as demonstrating positive behaviour to out-groups but negatively amongst themselves (Jost & Elsbach, 2001), in this study I have illuminated the reasons behind this behaviour, enhancing the Social Identity Approach by extending understanding of horizontal violence amongst subordinate groups. Horizontal violence encourages oppressive identity work within the professional group, inhibiting the construction of credible leadership identities.

I therefore offer a two-fold contribution to theory: extending understanding of the antecedents to distributed leadership; and illuminating the identity work employed by subordinate professionals undergoing identity conflict. The idea that a collective group identity is needed for the emergence of effective group leaders is reinforced, but the results also explore how this can be both problematic and detrimental for potential subordinate leaders, due to the incongruence between their traditional and new identities and roles. Examining the ways in which they overcome these obstacles has expanded understanding of how these subordinate groups behave differently from more powerful, traditional professions. The impact of these theoretical contributions on future practice and policy is considered below.

10.3 Implications for Policy and Practice

The development of existing theoretical assumptions creates interesting implications for future policy and practice, for both subordinate and superordinate professionals. The most immediate ramifications can be applied to the development of National Health Service policies. The current political agenda in the NHS is focused on the importance of distributed clinical leadership, increased professional leadership and inter-disciplinary working through a system of networks, rather than hierarchies (Darzi, 2008; DOH, 2009b, 2011a). Despite the rhetoric of joined-up clinical working, the focus of these policies has been on leadership from medical professionals. There are, therefore, a lot of assumptions about the ability of clinicians to take on and adapt to hybrid managerial leadership roles or exert professional influence in an informal manner. The policies which acknowledge the need for nursing leadership (DOH, 2008b) have also reflected these assumptions about identity congruence, assumptions which this study suggests are flawed. Distributed, professional leadership will only be successful amongst all professions in the NHS if the findings of this study can be acknowledged and addressed, otherwise the organisational status quo will be perpetuated, and nurses taking on non-prototypical roles will continue to struggle with identity conflict and lack of leadership influence.

The results identified a group of respondents who had created a 'Fused Hybrid' identity, personifying the successful transition into a service leader who could enact successful managerial and professional influence. However, these identity types were in the minority and were only enacted by individuals who had been in high, hierarchical positions for some time. The majority of respondents were 'Split Hybrids' who were characterised by occupying a liminal space. The results of this study support the need for extra support and interventions within this liminal space, in order to successfully develop more subordinate professionals into strategic leaders. By residing in a liminal space, the split hybrids should be positioned to work across boundaries, and are therefore the identity group which the majority of policies suggest are crucial for organisational change (Darzi, 2008; DOH, 2008b, 2010). In reality, this does not occur,

183

due to the negative identity conflicts and lack of influence amongst and outside of the profession. It is at this point in the identity transition process that leadership development and support needs to be focused.

The problems of current NHS leadership approaches, which place an emphasis on the panacea of leadership without consideration of professional or organisational mediation, have been criticised before (Bolden & Wood, 2006; Currie, Humprheys et al, 2008; Currie, Lockett & Suhomlinova, 2009a; O'Reilly & Reed, 2010). It is not effective to apply leadership development methods used with more traditional professions to subordinate professions, due to their unique problems with identity incongruence. Leadership development needs to be treated as a mediating mechanism to facilitate identity transitions (Carroll & Levy, 2010), rather than as a form of organisational control (Alvesson & Willmott, 2002).

In order to reduce the identity conflicts experienced by split hybrids, and increase their leadership influence, a leadership development programme is required at this stage, which is tailored specifically to the needs of this group. These needs include making individuals aware of the reasons behind their feelings of anxiety and conflict, in particular their inability to present themselves cohesively to others, one of the largest root causes of their identity conflicts and problems of legitimate influence. Rather than focussing on 'tick box exercises' (McGivern & Ferlie, 2007), leadership development programmes for conflicted individuals need to encourage consideration of intrinsic identity conflicts in a supportive and formative space (McGivern & Fischer, 2012). This will also need to be facilitated by an organisational context which acknowledges identity problems and attempts to mediate them by not making professionals conform to pre-existing managerial structures, but by allowing them to craft their own hybrid roles. Whether that will be possible in the current organisational climate of the NHS is unclear, as the system is still strongly influenced by central control.

In addition to interventions during leadership development forums, it would be beneficial to consider the influence of the professional socialisation of nurses on the construction of their salient group identity. It is this entrenched, socialisation process which creates the primary source of identity conflicts by creating a traditional prototype. This needs to be addressed during professional training, and support for non-prototypical behaviours given within teams. This is an exceptionally difficult task, and one that is an on-going process. However, nurse education is changing towards an all degree profession (Martin, 2009; NMC 2010), and as such the culture may begin to shift (although the issues associated with the wider NHS culture may still remain). Future nursing policy needs to focus on the development of the professional ideology, bringing it into line with the modern demands of nurses. Additionally, the identity conflicts inherent in nursing leadership roles need to be acknowledged and support systems put in place alongside the leadership development programmes run by NHS organisations. It may be that the RCN is ideally placed to offer programmes which specifically address professional identity development issues. Finally, nursing education and future policies need to address the horizontal violence and oppressive identity work which is rife within the profession. This may be achieved by the aforementioned development of the professional ideology, which needs to be adapted so that management is no longer seen as a 'dirty word', and those moving into management positions are still seen as 'proper nurses'.

The findings have illuminated identity issues related to leadership amongst nurses, but these results can be applied to any profession whose group identity and professional sphere is defined by subordination to a more professional group (Abbott, 1988). Within the NHS, these findings could apply to the majority of ancillary health professionals, such as Allied Health Professionals or supplementary non-registered nursing assistants, who continue to see their leadership dominated by the medical and managerial hierarchies, and their practice influenced by the traditional influence of nurses. Outside of the healthcare system, findings can be directly applied to other subordinate professions, such as paralegal staff and teaching assistants. These

professions will face similar problems to nurses, as their salient identity is orthogonal with the new leadership identity they are trying to construct.

In addition, whilst the results focused on issues related to subordinate professionals, they can also be widened out to our general understanding of professional identity and behaviour. In particular, issues illuminated about the loss of professional identity and role. This is acute amongst nurses, but can be applied to any professional group with a strong sense of identity, such as the stronger, traditional professions of medicine, law and accountancy (Iedema et al., 2004; Pratt et al., 2006). The organisational context of the research also allows findings to be generalised to experiences in other large, bureaucratic, pluralistic organisations, such as the education or defence sector (Denis et al., 2007; Fernandez, 2005; Gunz & Gunz, 2007). In particular, as the research was conducted in a healthcare setting, some of the results of the thesis, such as recommendations relating to an identity aspect of leadership development, could be generalised out to other healthcare professions such as medicine or the allied health professions.

These generaliseable results are particularly timely for the medical profession, given the current reforms encouraging GPs to take on commissioning roles (DH, 2011a). This study offers insights which could be used to understand the struggles GPs may face when attempting to construct a 'commissioning' identity, making decisions which may be incongruent with their 'GP' identity. Whilst previous research into professional identity work has been explored in a limited manner previously (Ibarra & Barbulescu, 2010), this study has extended existing knowledge by identifying three types of identity work used to construct four types of identity, something which has not previously been explored in detail. The increased understanding this study offers could potentially be used to facilitate the transition for GPs, by identifying junctures at which they will encounter conflict (for example during the split hybrid phase, trying to personify two separate, incongruent identities). Further research into this area would be interesting, and may illuminate further the transitioning process from split to fused hybrid professionals

186

10.4 Further avenues of research and study limits

In this study I have illuminated previously neglected elements of the understanding of distributed leadership and identity theory, and in doing so have generated new questions and avenues for research. I have explored how a move from prototypical professional to non-prototypical, influential strategic leader is a process of identity transition and construction, which is facilitated through different types of identity work. Whilst some insights have been offered into the nature of this transitioning process, more work is needed to fully understand how it occurs. It is unclear whether all individuals will pass through the liminal split phase, or whether some move directly to the fused hybrid identity. How, exactly, individuals will move from a split to fused hybrid is unclear. In this study it seems to be primarily related to job role, but it is highly likely there are other, more nuanced, processes at play. The antecedents to these identity transitions need further exploration and consideration, to determine how the process can be facilitated. The mediating influence of leadership development programmes as a site of identity transition should also be the focus of future research, particularly where programmes are not just systems of organisational control. Perhaps simulating an identity based leadership development programme, and examining resulting identity transitions and constructions, would provide insights into the specific nature of the programmes needed to facilitate professional identity transition.

The increased understanding of horizontal violence amongst subordinate professions was an interesting outcome of this study, and one which also demands further exploration. It is this demonising behavior and oppressive identity work which contributes to the perpetual undermining of subordinate leaders from within their own professional group. A further examination of this issue and recommendations about how to prevent it, or temper the effects on group leadership, are required to further support non-prototypical leaders in their roles.

The nursing profession is facing a number of dramatic changes in the immediate future. The changing nature of nursing education means that by 2012 all registered nurses will be educated to a degree level (Martin, 2009; NMC 2010). Reflecting the increasingly autonomous and technical nature of nursing work, completing the move from vocational to professional training within a higher education setting, may have an interesting impact on the nature of nurses' subordinate identities. The discrepancy between modern nurse roles and the traditional, vocational images held about them have been researched previously (Apesoa-Varano, 2007). Exploration of the impact of increased educational training on acceptance as influential service leaders, as well as the influence on group identity, is needed.

The change in academic professional requirements also comes at a time when the NHS itself faces wide organisational change (DOH, 2010, 2011a). Research is needed into the impacts of these changes on nursing leadership. Whilst the move is towards clinician led commissioning, the focus has once again been on the importance of medical leadership, such as GP commissioning groups, with supplementary nurse and AHP involvement. The impact this has on subordinate group leadership, and their influence within the health service, warrants substantial exploration once the changes have been imposed.

The nature of the study design has imposed limits on the research. Data was collected over a two-year period in an NHS Trust, and therefore can only offer a temporal snapshot of the organisation at that time. Large organisations are notoriously dynamic, and the NHS was undergoing large amounts of politically driven change over this time. Therefore some elements of findings, such as the removal of nursing leadership posts due to austerity measures, may have been responsive to temporal influences. Despite this limitation the study design, in-depth exploration of identity construction through longitudinal interviews, offered rich insight into the conflicts encountered by respondents. The semi-structured interviews allowed respondents to engage in narrative identity work with me, illuminating the processes by which they tried to construct identities. By focussing on subordinate individuals, I am able to generalise findings out beyond the nursing

profession, to traditional professionals as well as to other subordinate groups. Additionally, due to the complex organisational context of the NHS, the findings can be used to guide understandings of phenomenon in other complex organisational structures.

10.5 The Researcher Journey

In a study which relies on the development and construction of shared meaning through interview discussions between participant and researcher, it is necessary to consider the influence of the researcher's own identity on the process. My professional background is as a Registered Nurse, which provided an interesting juxtaposition between my salient professional identity and my new identity as a 'researcher'. This section considers the impact of my identity on the research process, as well as the reciprocal influence the three-year PhD experience has had on my own identity.

During the process of study design it was clear that researcher reflexivity would be key during the process of data collection, so as not to project my own assumptions or experiences of leadership onto the interview (Fontana & Frey, 2003). Initially keen not to bias interviews through knowledge of our shared professional background, I decided not to tell respondents I was a Registered Nurse unless they specifically asked. What subsequently became clear to me during the process of data collection was the way attitudes and types of identity work changed towards me when participants found out about my background. For some, it engendered a sense of collegiality and shared identity, leading to them speaking much more candidly about the conflicts and obstacles they had faced. Whilst they may previously have been guarded as they viewed me as a 'Researcher' who did not understand what they perceived as the special nature of nursing, when they viewed me as 'Nurse' their attitudes changed demonstrably, and they were more open in their speech – almost as if they were sharing professional secrets with me. We both engaged in narrative identity work to construct a shared identity. However, for others the revelation that I was a nurse could lead to negative attitudes. In a similar manner to those taking

189

on managerial positions, I had moved away from prototypical behaviours to take on a research position. Some participants made quite negative comments about nurses moving into research, engaging in oppressive identity work and attempting to undermine my credible identity because I was no longer seen as a prototypical group member.

My own responses to interviews and reactions to my professional background were also interesting. When faced with negative comments about the irrelevance of nurses who had moved into research, I was quick to clarify that I still maintained a clinical role by working occasional nursing shifts. On reflection, I was displaying the same behaviours as split hybrids, attempting to achieve influence by constructing different identities in different environments. To engender influence and a sense of legitimacy within the Business School and the context of my PhD, I attempted to construct a 'PhD Researcher' identity. To gain influence and a sense of credibility among study respondents, I attempted to retain my identity as 'Nurse'. I began to realise I was in a liminal space.

Whilst split hybrids found the liminal space a potentially negative experience, due to their conflicted role demands, I was able to use it to my advantage. I did not have to enact leadership amongst this group, I merely had to engender a sense of collegiality in order to extract candid interview discourse from them, and in most cases this was a success. In addition, my background as a nurse, and my experiences of clinical work, gave me an insight into the professional issues influencing leadership amongst this group. My own experiences allowed me to identify areas where conflict might be arising and explore them further, subsequently adding a depth and richness to the exploration of identity issues within the study.

Objectivity was never going to be possible in this study. As acknowledged, nurses' professional identity is usually salient even in non-prototypical roles. It is clear that this also related to me, sometimes making it difficult to view data objectively. However, viewing it reflexively allowed me

to acknowledge the influence of my professional identity and harness it. Triangulating data with my two non-nursing supervisors, and using general organisational and behavioural theories to guide data coding, ensured the results were not too heavily influenced by my professional identity. In reality, on occasion I was disappointed the results led to negative conclusions about the profession who I identify so strongly with, or at least used to identify strongly with.

When I began the PhD I was clear that 'I am a Nurse' and my focus was on protecting that identity, and furthering the development of nursing research. Three years on, and I have had to deal with my own identity conflicts, resolution and new identity construction. Reflecting on this process, I can see how my identity transition echoes the stories told by the study respondents. I began my professional nursing career by being socialised into a prototypical identity during my undergraduate training. I began a nursing job, clear about my identity as a 'Clinician'. When I began working towards my PhD I moved into a job role which made it difficult for me to maintain my clinical background and traditional identity. I attempted to retain some element of clinical contact through occasional nursing shifts, but found myself feeling isolated and experiencing feelings of anxiety about the legitimacy of my identity. I did not view myself as a member of the Business School but yet I was not a 'proper' nurse. I was a split hybrid in a liminal space, attempting to portray a different identity to achieve legitimacy in different contexts. This was an uncomfortable identity construction. To resolve these issues I began to adapt my identity and move towards a new one: a researcher with a background in nursing, which offers insights into organisational and professional behaviour. This resolution has allowed me to move away from the traditional nursing role and begin to actively seek out employment within the Business School context, where I now believe my identity is legitimate. I have moved into a fused hybrid identity; a new construction which allows me to combine two professional identities with limited internal conflict.

10.6 Conclusion

In this study I have offered new insights into the process of leadership emergence amongst subordinate groups, contributing significantly to the understanding of the theory of distributed leadership, by viewing a leadership identity as a socially constructed phenomenon. Impacts of these theoretical contributions on the development of new Government policies have been considered, and recommendations made for leadership development programmes, and interventions in practice. These results were focused specifically on the issues encountered by nurses, but the findings can be widened out to professions in different contexts, as well as ancillary professionals in the NHS. Whilst the main findings of the work focus primarily on the incongruence between subordinate professional identities and leadership, the conclusions can also be applied to superordinate, traditional professions, with respect to salient professional identities. The way in which salient professional identities had to be adapted to allow managerial leadership, which was in turn guided by professional values to allow influence across boundaries, can be extended to reflect the demands of any professional-managerial hybrid. Whilst the limitations of the qualitative study were acknowledged, reflections on the nature of my own professional background added a depth to the understanding and exploration of identity issues.

11 References

Abbott, A. 1988. *The System of Professions: An Essay on the Division of Expert Labour*. London: The University of Chicago Press.

Abbott, P., & Meerabeau, L. 1998. Professionals, Professionalism and the Caring Professions. In P. Abbott, & L. Meerabeau (Eds.), *The Sociology of the Caring Professions*: 1-19. London: UCL Press.

Abrahamson, E. 1996. Management Fashion. *Academy of Management Review*, 21(1): 254-285.

Agle, B. R., Nagarajan, N. J., Sonnenfeld, J. A., & Srinivasan, D. 2006. Does CEO charisma matter? An empirical analysis of the relationships among organizational performance, environmental uncertainity, and top management team perceptions of CEO charisma. *Academy of Management Journal*, 49(1): 161-174.

Agranoff, R. 2006. Inside Collaborative Networks: Ten Lessons for Public Managers. *Public Administration Review*, 66(s1): 56-65.

Ahern, K. 1999. Ten Tips for Reflexive Bracketing. *Qualitative Health Research*, 9(3): 407-411.

Ahmad, Y., & Broussine, M. 2003. The UK public sector modernization agenda. *Public Management Review*, 5: 45-62.

Ahn, M. J., Adamson, J. S. A., & Dornbusch, D. 2004. From Leaders to Leadership: Managing Change. *Journal of Leadership and Organizational Studies*, 10(4): 112-123.

Ainsworth, S., Grant, D., & Iedema, R. 2009. 'Keeping things moving': Space and the construction of middle management identity in a post-NPM organization. *Discourse and Communication*, 3(1): 5-25.

Alasliutari, P. 1995. *Researching Culture: Qualitative Method and Cultural Studies*. London: Sage.

Allen, D. 1997. The nursing-medical boundary: a negotiated order? *Sociology of Health & Illness*, 19(4): 498-520.

Allen, D. 2007. What do you do at work? Profession building and doing nursing. *International Nursing Review*, 54(1): 41-48.

Alvesson, M. 1996. Leadership Studies: From procedure and abstraction to reflexivity and situation. *The Leadership Quarterly*, 7(4): 455-485.

Alvesson, M., & Sveningsson, S. 2003a. Good Visions, Bad Micro-management and Ugly Ambiguity: Contradictions of (Non-)Leadership in a Knowledge-Intensive Organization. *Organization Studies*, 24(6): 961-988.

Alvesson, M., & Sveningsson, S. 2003b. The great disappearing act: difficulties in doing "leadership". *The Leadership Quarterly*, 14(3): 359-381.

Alvesson, M., & Sveningsson, S. 2003c. Managers doing leadership: The extra-ordinarization of the mundane. *Human Relations*, 56(12): 1435-1459.

Alvesson, M., & Willmott, H. 2002. Identity Regulation as Organizational Control: Producing the Appropriate Individual. *Journal of Management Studies*, 39(5): 619-644.

Anderson, P. 1999. Perspective: Complexity Theory and Organization Science. *Organization Science*, 10(3): 216-232.

Antonakis, J., Avolio, B. J., & Sivasubramaniam, N. 2003. Context and leadership: an examination of the nine-factor full-range leadership theory using the Multifactor Leadership Questionnaire. *The Leadership Quarterly*, 14(3): 261-295.

Antonsen, M., & Jorgensen, T. B. 1997. The Publicness of Public Organizations. *Public Administration*, 75: 337-357.

Apesoa-Varano, E. C. 2007. Educated Caring: The Emergence of Professional Identity Among Nurses. *Qualitative Sociology*(30): 249-274.

Appleby, J., Crawford, R. & Emmerson, C. 2009. *How Cold Will it be? Prospects for NHS Funding 2011-17* London: The Kings Fund

Ashforth, B., & Humphrey, R. 1993. Emotional Labor in Service Roles: The Influence of Identity. *Academy of Management Review*, 18(1): 88-115.

Ashforth, B., & Johnson, S. 2001. Which Hat to Wear? The relative salience of multiple identities in organizational contexts. In M. A. Hogg, & L. D. Terry (Eds.), *Social Identity Processes in Organizational Contexts*: 31-48. Sussex: Psychology Press.

Ashforth, B., & Kreiner, G. 1999. "How can you do it?": Dirty work and the challenge of contructing a positive identity. *Academy of Management Review*, 24(3): 413-434.

Ashforth, B., Kreiner, G., Clark, M., & Fugate, M. 2007. Normalizing Dirty Work: Managerial Tactics for Countering Occupational Taint. *The Academy of Management Journal ARCHIVE*, 50(1): 149-174.

Ashforth, B., & Mael, F. 1989. Social Identity Theory and the Organization. *Academy of Management Review*, 14(1): 20-39.

Aucoin, P., & Heintzman, R. 2000. The Dialectics of Accountability for Performance in Public Management Reform. *International Review of Administrative Sciences*, 66(1): 45-55.

Avery, G. 2004. *Understanding Leadership*. London: Sage.

Avolio, B. J., & Bass, B. M. 1995. Individual consideration viewed at multiple levels of analysis: A multi-level framework for examining the diffusion of transformational leadership. *The Leadership Quarterly*, 6(2): 199-218.

Avolio, B. J., Bass, B. M., & Jung, D. I. 1999. Re-examining the components of transformational and transactional leadership using the Multifactor Leadership. *Journal of Occupational and Organizational Psychology*, 72: 441-462.

Avolio, B. J., & Gardner, W. L. 2005. Authentic leadership development: Getting to the root of positive forms of leadership. *The Leadership Quarterly*, 16(3): 315-338.

Avolio, B. J., Reichard, R. J., Hannah, S. T., Walumbwa, F. O., & Chan, A. 2009. A meta-analytic review of leadership impact research: Experimental and quasi-experimental studies. *The Leadership Quarterly*, 20(5): 764-784.

Avolio, B. J., Sivasubramaniam, N., Murry, W., Jung, D. I., & Garger, J. 2003. Assessing shared leadership: Development and preliminary validation of a team Multifactor Leadership Questionnaire. In C. L. Pearce, & J. A. Conger (Eds.), *Shared Leadership: Reframing the hows and whys of leadership*. London: Sage.

Baer, E. 1997. Women and the Politics of Career Development: The Case of Nursing. In A. M. Rafferty, J. Robinson, & R. Elkan (Eds.), *Nursing History and the Politics of Welfare*: 242-258. London: Routledge.

Baggott, R. 1998. *Health and Healthcare in Britain* (2nd ed.). London: Macmillan Press.

Baldwin, J. N. 1987. Public versus Private: Not that different, Not that consequential. *Public Personnel Management*, 16(2): 181-193.

Balkundi, P., & Kilduff, M. 2005. The ties that lead: A social network approach to leadership. *The Leadership Quarterly*, 16(6): 941-961.

Barker, R. 1997. How Can We Train Leaders if We Do Not Know What Leadership Is? *Human Relations*, 50(4): 343-362.

Barker, R. A. 2001. The Nature of Leadership. *Human Relations*, 54(4): 469-494.

Basadur, M. 2004. Leading others to think innovatively together: Creative leadership. *The Leadership Quarterly*, 15(1): 103-121.

Bass, B. M. 1985. *Leadership and Performance Beyond Expectations*. New York: Free Press.

Bass, B. M. 1990a. *Bass & Stogdill's Handbook of Leadership: Theory, research and managerial applications*. New York: The Free Press.

Bass, B. M. 1990b. From transactional to transformational leadership: Learning to share the vision. *Organizational Dynamics*, 18(3): 19-31.

Baxter, J. 2010. *The Langauge of Female Leadership*. Hampshire: Palgrave Macmillan.

Beck, C. T. 1999. Quantitative measurement of caring. *Journal of Advanced Nursing*, 30(1): 24-32.

Becker, H. S., & Carper, J. W. 1956. The Development of Identification with an Occupation. *American Journal of Sociology*, 61(4): 289-298.

Bedell-Avers, K., Hunter, S. T., Angie, A. D., Eubanks, D. L., & Mumford, M. D. 2009. Charismatic, ideological, and pragmatic leaders: An examination of leader-leader interactions. *The Leadership Quarterly*, 20(3): 299-315.

Bedell-Avers, K. E., Hunter, S. T., & Mumford, M. D. 2008. Conditions of problem-solving and the performance of charismatic, ideological, and pragmatic leaders: A comparative experimental study. *The Leadership Quarterly*, 19(1): 89-106.

Beech, N. 2008. On the Nature of Dialogic Identity Work. *Organization*, 15(1): 51-74.

Beech, N. 2011. Liminality and the practices of identity reconstruction. *Human Relations*, 64(2): 285-302.

Benington, J. 2000. The Modernization and Improvement of Government and Public Services. *Public Money & Management*, 20(2): 3 - 8.

Berger, J., Balkwell, J., Norman, R., & Smith, R. 1992. Status Inconsistency in Task Situations: A Test of Four Status Processing Principles. *American Sociological Review*, 57(6): 843-855.

Berson, Y., Shamir, B., Avolio, B. J., & Popper, M. 2001. The relationship between vision strength, leadership style, and context. *The Leadership Quarterly*, 12(1): 53-73.

Bevan, G., & Hood, C. 2006. Whats measured it what matters: Targets and gaming in the English public health care system. *Public Administration*, 84: 517-538.

Bhatta, G. 2003. *Working Paper No. 17: Post-NPM Themes in Public Sector Government. In S. S. Commission* (Ed.). New Zealand.

Björkström, M., Johansson, I., & Athlin, E. 2006. Is the humanistic view of the nurse role still alive – in spite of an academic education? *Journal of Advanced Nursing*, 54(4): 502-510.

Bjugstad, K., Tach, E., Thompson, K., & Morris, A. 2006. A fresh look at followership: A model for matching followership and leadership styles. *Journal of Behavioral and Applied Management*, 7: 304-319.

Blair, T. 1999. *Modernising Government*. Cabinet Office (Ed.). London: HMSO.

Bligh, M., Kohles, J., & Meindl, J. 2004. Charting the language of leadership: A methodological investigation of President Bush and the crisis of 9/11. *Journal of Applied Psychology*, 89(3): 562-574.

Bojtor, A. 2003. The importance of social and cultural factors to nursing status. *International Journal of Nursing Practice*, 9(5): 328-335.

Bolden, R., & Gosling, J. 2006. Leadership Competencies: Time to Change the Tune? *Leadership*, 2(2): 147-163.

Bolden, R., Petrov, G., & Gosling, J. 2009. Distributed Leadership in Higher Education: Rhetoric and Reality. *Educational Management Administration Leadership*, 37(2): 257-277.

Bolden, R., Wood, M., & Gosling, J. 2006. Is the NHS Leadership Qualities Framework Missing the Wood for the Trees? In A. Casbeer, A. Hamson, & A. Mark (Eds.), *Innovations in Health Care: A Reality Check*: 17-29. New York: Palgrave Macmillan.

Bolton, S. 2005. Women's Work, Dirty Work: The Gynaecology Nurse as 'Other'. *Gender, Work and Organization*, 12(2): 169-186.

Bolton, S. C. 2000. Nurses as managers: between a professional rock and an HRM hard place? *Human Resource Development International*, 3(2): 229-234.

Bommer, W. H., Rubin, R. S., & Baldwin, T. T. 2004. Setting the stage for effective leadership: Antecedents of transformational leadership behavior. *The Leadership Quarterly*, 15(2): 195-210.

Borins, S. 2000. Loose Cannons and Rule Breakers, or Enterprising Leaders? Some Evidence About Innovative Public Managers. *Public Administration Review*, 60: 498-507.

Boyne, G., A. 2002. Public and Private Management: What's the Difference? *Journal of Management Studies*, 39(1): 97-122.

Boyne, G. A. 1998. Public Services Under New Labour: Back to Bureaucracy? *Public Money & Management*, 18: 43-50.

Brass, D., Galaskiewicz, J., Greve, H., & Tsai, W. 2004. Taking Stock of Networks and Organizations: A Multilevel Perspective. *Academy of Management Journal*, 47(6): 795-817.

Bresnen, M. J. 1995. All things to all people? Perceptions, attributions, and constructions of leadership. *The Leadership Quarterly*, 6(4): 495-513.

Brewer, M. & Gardner, W. 1996. Who is this 'We'? Levels of Collective Identity and Self Representations. *Journal of Personality and Social Psychology* 71(1): 83-93

Brickson, S., & Brewer, M. 2001. Identity Orientation and Intergroup Relations in Organizations. In M. A. Hogg, & L. D. Terry (Eds.), *Social Identity Processes in Organizational Contexts*: 49-65. Sussex: Psychology Press.

Bringer, J., Johnston, L., & Brackenrisge, C. 2004. Maximising transparency in a doctoral thesis: the complexities of writing about the use of QSR*NVivo within a grounded theory study. *Qualitative Research*, 4(2): 247-265.

Broadbent, J., & Laughlin, R. 2002. Public Service Professionals and the New Public Management. In K. McLaughlin, S. Osborne, & E. Ferlie (Eds.), *New Public Management: Current trends and future prospects*: 95-108. London: Routledge.

Brodkin, E. Z. 2007. Bureaucracy Redux: Management Reformism and the Welfare State. *Journal of Public Administration Research & Theory*, 17(1): 1-17.

Brooks, I. 1996. Using ritual to reduce barriers between sub-cultures. *Journal of Management in Medicine*, 10(3): 23-30.

Brown, A. D. & Humphreys, M. 2006. Organizational Identity and Place: A Discursive Exploration of Hegemony and Resistance. *Journal of Management Studies* 43(2): 231-257

Brown, A. D., & Lewis, M. A. 2011. Identities, Discipline and Routines. *Organization Studies*, 32(7): 871-895.

Bryman, A. 1984. The debate about Quantiative and Qualitative Research: A Question of Method or Epistemology? *The British Journal of Sociology*, 35(1): 75-92.

Bryman, A. 1988. *Quantity and Quality in Social Research*. London: Routledge.

Bryman, A. 1999. Leadership in Organisations. In S. Clegg, C. Hardy, & W. Nord (Eds.), *Managing Organizations: Current Issues*. London: Sage.

Bryman, A. 2004. Qualitative research on leadership: A critical but appreciative review. *The Leadership Quarterly*, 15(6): 729-769.

Bryman, A., Stephens, M., & Campo, C. à. 1996. The importance of context: Qualitative research and the study of leadership. *The Leadership Quarterly*, 7(3): 353-370.

Buchanan, D. A., Addicott, R., Fitzgerald, L., Ferlie, E., & Baeza, J. I. 2007. Nobody in charge: Distributed change agency in healthcare. *Human Relations*, 60(7): 1065-1090.

Buckingham, M. 2005. What Great Managers DO. *Harvard Business Review*, 83(3): 70-79.

Budig, M. 2002. Male Advantage and the Gender Composition of Jobs: Who Rides the Glass Escalator? *Social Problems*, 49(2): 258-277.

Burns, J. 1978. *Leadership*. New York: Harper & Row.

Calas, M. 1993. Deconstructing charismatic leadership: re-reading Weber from the darker side. *The Leadership Quarterly*, 4(3/4): 395-328.

Cameron, A., & Masterson, A. 2000. Managing the unmanageable? Nurse Executive Directors and new role developments in nursing. *Journal of Advanced Nursing*, 31(5): 1081-1088.

Campbell-Heider, N., & Pollock, D. 1987. Barriers to physician-nurse collegiality: An anthropological perspective. *Social Science & Medicine*, 25(5): 421-425.

Carroll, B., & Levy, L. 2008. Defaulting to Management: Leadership Defined By What It Is Not. *Organization*, 15(1): 75-96.

Carroll, B., & Levy, L. 2010. Leadership Development as Identity Construction. *Management Communication Quarterly*, 24(2): 211-231.

Carson, J. B., Tesluk, P. E., & Marrone, J. A. 2007. Shared leadership in teams: An investigation of antecedent conditions and performance. *Academy of Management Journal*, 50(5): 1217.

Cerulo, K. (1997) Identity Construction: New Issues, New Directions. *Annual Review of Sociology,* 23: 385-409

Chan, S. 2002. Factors influencing nursing leadership effectiveness in Hong Kong. *Journal of Advanced Nursing*, 38(6): 615-623.

Charles-Jones, H., Latimer, J., & May, C. 2003. Transforming general practice: the redistribution of medical work in primary care. *Sociology of Health & Illness*, 25(1): 71-92.

Chemers, M. 2003. Leadership Effectiveness: functional, constructivist and empirical perspectives. In D. Van Knippenberg, & M. A. Hogg (Eds.), *Leadership and Power - Identity processes in groups and organizations*: 5-17. London: Sage.

Christensen, T. 2001. Administrative Reform: Changing Leadership Roles? *Governance*, 14(4): 457-480.

Christensen, T., & LÆGreid, P. 2003. Coping with Complex Leadership Roles: The Problematic Redefinition of Government-owned Enterprises. *Public Administration*, 81(4): 803-831.

Chua, W. F., & Clegg, S. 1989. Contradictory Couplings: Professional Ideology in the Organizational Locales of Nurse Training *Journal of Management Studies*, 26(2): 103-127.

Chun, J. U., Yammarino, F. J., Dionne, S. D., Sosik, J. J., & Moon, H. K. 2009. Leadership across hierarchical levels: Multiple levels of management and multiple levels of analysis. *The Leadership Quarterly*, 20(5): 689-707.

Clarke, C. A., Brown, A. D., & Hailey, V. H. 2009. Working identities? Antagonistic discursive resources and managerial identity. *Human Relations*, 62(3): 323-352.

Coffey, A., & Atkinson, P. 1996. *Making Sense of Qualitative Data*. London: Sage.

Collins, J. 2001. LEVEL 5 LEADERSHIP. *Harvard Business Review*, 79(1): 66-76.

Collinson, D. 2006. Rethinking followership: A post-structuralist analysis of follower identities. *The Leadership Quarterly*, 17(2): 179-189.

Conger, J. A. 1998. Qualitative research as the cornerstone methodology for understanding leadership. *The Leadership Quarterly*, 9(1): 107-121.

Connelly, M. S., Gilbert, J. A., Zaccaro, S. J., Threlfall, K. V., Marks, M. A., & Mumford, M. D. 2000. Exploring the relationship of leadership skills and knowledge to leader performance. *The Leadership Quarterly*, 11(1): 65-86.

Cott, C. 1998. Structure and Meaning in Multidisciplinary Teamwork. *Sociology of Health & Illness*, 20(6): 848-873.

Creed, W., Scully, M., & Austin, J. 2002. Clothes Make the Person? The Tailoring of Legitimating Accounts and the Social Construction of Identity. *Organization Science*, 13(5): 475-496.

Crocker, J., & Park, L. 2003. Seeking Self-Esteem: Construction, maintenance, and protection of self-worth. In M. Leary, & J. Tangney (Eds.), *The Handbook of Self and Identity*: 291-313. London: The Guildford Press.

Cross, S., & Bagilhole, B. 2002. Girls Jobs for the Boys? Men, Masculinity and Non-Traditional Occupations. *Gender, Work and Organization*, 9: 204-226.

Cummings, G., Lee, H., MacGregor, T., Davey, M., Wong, C., Paul, L., & Stafford, E. 2008. Factors contributing to nursing leadership: a systematic review. *Journal of Health Services Research & Policy*, 13(4): 240-248.

Cunliffe, A. 2003. Reflexive inquiry in organizational research: Questions and possibilities. *Human Relations*, 56(8): 983-1003.

Currie, G. 2006. Reluctant but resourceful middle managers: the case of nurses in the NHS. *Journal of Nursing Management*, 14(1): 5-12.

Currie, G., Boyett, I., & Suhomlinova, O. 2005. Transformational Leadership within Secondary Schools in England. A Panacea for Organizational Ills? *Public Administration*, 83(2): 265-296.

Currie, G., Finn, R., & Martin, G. 2010. Role Transition and the Interaction of Relational and Social Identity: New Nursing Roles in the English NHS. *Organization Studies*, 31(7): 941-961.

Currie, G., Humphreys, M., Ucbasaran, D., & McManus, S. 2008. Entrepreneurial Leadership in the English Public Sector: Paradox or Possibility? . *Public Administration*, 86(4): 987-1008.

Currie, G., & Lockett, A. 2007. A critique of transformational leadership: Moral, professional and contingent dimensions of leadership within public services organizations. *Human Relations*, 60(2): 341-370.

Currie, G., Lockett, A., & Suhomlinova, O. 2009a. Leadership and institutional change in the public sector: The case of secondary schools in England. *The Leadership Quarterly*, 20(5): 664-679.

Currie, G., Lockett, A., & Suhomlinova, O. 2009b. The institutionalization of distributed leadership: A 'Catch-22' in English public services. *Human Relations*, 62(11): 1735-1761.

Currie, G., & Procter, S. J. 2005. The Antecedents of Middle Managers' Strategic Contribution: The Case of a Professional Bureaucracy. *Journal of Management Studies*, 42(7): 1325-1356.

Currie, G., & Suhomlinova, O. 2006. The Impact of Institutional Forces Upon Knowledge Sharing in the UK NHS: The Triumph of Professional Power and the Inconsistency of Policy. *Public Administration*, 84: 1-30.

Curtis, S., Gesler, W., Smith, G., & Washburn, S. 2000. Approaches to sampling and case selection in qualitative research: examples in the geography of health. *Social Science & Medicine*, 50: 1001-1014.

Czarniawska-Jorges, B. 2010. Narratives of Individual and Organizational Identities. In Hatch, M. & Schultz, M. (Eds) *Organizational Identity: A Reader* Oxford: Oxford University Press

Darzi. 2008. *High Quality Care for All: NHS Next Stage Review*. Department of Health. London: HMSO.

Davies, C. 2004. Political leadership and the politics of nursing. *Journal of Nursing Management*, 12(4): 235-241.

Davies, K. 2003. The body and doing gender: the relations between doctors and nurses in hospital work. *Sociology of Health & Illness*, 25(7): 720-742.

Dawson, S., & Dargie, C. 2002. New Public Management: A discussion with special reference to UK health. In K. McLaughlin, S. Osborne, & E. Ferlie (Eds.), *New Public Management: Current trends and future prospects*: 34-56. London: Routlege.

Dawson, S., Garside, P., Hudson, R., & Bicknell, C. 2004. *The design and establishment of the Leadership Council* London: Department of Health.

Day, D. V. 2000. Leadership development:: A review in context. *The Leadership Quarterly*, 11(4): 581-613.

Day, D. V., Gronn, P., & Salas, E. 2004. Leadership capacity in teams. *The Leadership Quarterly*, 15(6): 857-880.

Day, D. V., Gronn, P., & Salas, E. 2006. Leadership in team-based organizations: On the threshold of a new era. *The Leadership Quarterly*, 17(3): 211-216.

Day, D. V., & Harrison, M. M. 2007. A multilevel, identity-based approach to leadership development. *Human Resource Management Review*, 17(4): 360-373.

Delamont, S. 2007. Ethnography and participant observation. In C. Seale, G. Gobo, J. Gubrium, & D. Silverman (Eds.), *Qualitative Research Practice*: 205-217. London: Sage.

Den Hartog, D. N., House, R. J., Hanges, P. J., Ruiz-Quintanilla, S. A., & Dorfman, P. W. 1999. Culture specific and cross-culturally generalizable implicit leadership theories: Are attributes of charismatic/transformational leadership universally endorsed? *The Leadership Quarterly*, 10(2): 219-256.

Denis, J.-L., Lamothe, L., & Langley, A. 2001. The dynamics of collective leadership and strategic change in pluarlistic organizations. *Academy of Management Journal*, 44(4): 809-837.

Denis, J.-L., Langley, A., & Cazale, L. 1996. Leadership and Strategic Change under Ambiguity. *Organization Studies*, 17(4): 673-699.

Denis, J.-L., Langley, A., & Rouleau, L. 2005. Rethinking Leadership in Public Organisations. In E. Ferlie, C. Pollitt, & L. E. Lynn Jr (Eds.), *The Oxford Handbook of Public Management*: 446-467. Oxford.

Denis, J.-L., Langley, A., & Rouleau, L. 2007. Strategizing in pluralistic contexts: Rethinking theoretical frames. *Human Relations*, 60(1): 179-215.

Denzin, N., & Lincoln, Y. 2003. Introduction: The discipline and practice of qualitative reseach. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials*, 2 ed.: 1-45. London: Sage.

DeRue, D., & Ashford, S. 2010. Who Will Lead and Who Will Follow? A Social Process of Leadership Identity Construction in Organizations. *Academy of Management Review*, 35(4): 627-647.

Dess, G. G., & Picken, J. C. 2000. Changing Roles: Leadership in the 21st Century. *Organizational Dynamics*, 28: 18-33.

Diefenbach, T., & Sillince, J. A. A. 2011. Formal and Informal Hierarchy in Different Types of Organization. *Organization Studies*, 32(11): 1515-1537.

Dingwall, R. 1997. Accounts, Interviews and Observations. In G. Miller, & R. Dingwall (Eds.), *Context and Method in Qualitative Research*: 51-65. London: Sage.

Dingwall, R., Rafferty, A. M., & Webster, C. 1993. *An Introduction to the Social History of Nursing*. London: Routledge.

Dionne, S. D., & Dionne, P. J. 2008. Levels-based leadership and hierarchical group decision optimization: A simulation. *The Leadership Quarterly*, 19(2): 212-234.

Dixon, A. & Ham, C. 2010. *Liberating the NHS: The Right Prescription in a Cold Climate? The Kings Fund Response to the 2010 White Paper* London: The Kings Fund

Department Of Health. 1989. *Working for Patients* London: HMSO.

Department Of Health. 1996. *The National Health Service: A Service with Ambitions.* London: HMSO.

Department Of Health. 1997. *The New NHS: Modern, Dependable* London: HMSO.

Department Of Health. 2000. *The NHS Plan: A Plan for Investment, A Plan for Reform.* London: HMSO.

Department Of Health. 2004. *Agenda for Change Final Agreement.* London: HMSO.

Department Of Health. 2008a. *Framing the Contribution of Allied Health Professionals: Delivering High-Quality Healthcare.* London: HMSO.

Department Of Health. 2008b. *Framing the Nursing and Midwifery Contribution: Driving up the Quality of Care.* London: HMSO.

Department Of Health. 2009a. *Clinical Commissioning: Our Vision for Practice Based Commissioning.* London: DOH.

Department Of Health. 2009b. *Clinical commissioning: our vision for practice based care.* London: HMSO.

Department Of Health. 2009c. *Inspiring Leaders: Leadership for Quality* London: HMSO

Department Of Health. 2010. *Equity and Excellence: Liberating the NHS.* London: HMSO

Department Of Health. 2011a. *The functions of GP commissioning consortia: a working document.* London: HMSO.

Department Of Health. 2011b. *Developing Clinical Commissioning Groups: Towards Authorisation*. London: DOH.

Department Of Health. 2011c. *Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS.* London: DOH.

Dorfman, P. W., & Howell, J. P. 1997. Leadership in Western and Asian countries: Commonalities and differences in effective leadership. *Leadership Quarterly*, 8(3): 233.

Drath, W. H., McCauley, C. D., Palus, C. J., Van Velsor, E., O'Connor, P. M. G., & McGuire, J. B. 2008. Direction, alignment, commitment: Toward a more integrative ontology of leadership. *The Leadership Quarterly*, 19(6): 635-653.

Dunleavy, P., & Hood, C. 1994. From old public administration to new public management. *Public Money & Management*, 14(3): 9 - 16.

Dunleavy, P., Margetts, H., Bastow, S., & et al. 2006. New public management is dead-long live digital-era governance. *Journal of Public Administration Research & Theory*, 16(3): 467.

Dunning, D. 2003. The Relation of Self to Social Perception. In M. Leary, & J. Tangney (Eds.), *The Handbook of Self and Identity*: 421-441. London: The Guildford Press.

Eagly, A., & Johannesen-Schmidt, M. 2001. The Leadership Styles of Women and Men. *Journal of Social Issues*, 57(4): 781-797.

Edmonstone, J., & Western, J. 2000. Leadership development in healthcare: what do we know? *Journal of Management in Medicine*, 16(1): 34-47.

Edwards, B. 1995. *The National Health Service: A Manager's Tale*. London: Nuffield Provincial Hospitals Trust.

Eisenhardt, K. 1989. Building Theories from Case Study Research. *Academy of Management Review*, 14(4): 532-550.

Eisenhardt, K., & Graebner, M. 2007. Theory building from cases: opportunities and challenges. *Academy of Management Journal*, 50(1): 25-32.

El-Sawad, A., Arnold, J., & Cohen, L. 2004. 'Doublethink': The prevalence and function of contradiction in accounts of organizational life. *Human Relations*, 57(19): 1179-1203.

Ellemers, N., Spears, R., & Doosje, B. 2002. Self and Social Identity. *Annual Review of Psychology*, 53(1): 161-186.

Ellis, N., & Ybema, S. 2010. Marketing Identities: Shifting Circles of Identification in Inter-organizational Relationships. *Organization Studies*, 31(3): 279-305.

Elsbach, K., & Bhattacharya, C. 2001. Defining Who You Are by What You're Not: Organizationl Disidentification and the National Rifle Association. *Organization Science*, 12(4): 393-413.

Ensley, M. D., Hmieleski, K. M., & Pearce, C. L. 2006. The importance of vertical and shared leadership within new venture top management teams: Implications for the performance of startups. *The Leadership Quarterly*, 17(3): 217-231.

Epitropaki, O., & Martin, R. 2005. From Ideal to Real: A longitudinal study of the role of implicit leadership theories on leader-member exchanges and employee outcomes. *Journal of Applied Psychology*, 90(4): 659-676.

Fagermoen, M. 1997. Professional identity: values embedded in meaningful nursing practice. *Journal of Advanced Nursing*, 25(3): 434-441.

Fagin, C. (Ed.). 2000. *Essays on Nursing Leadership*. New York: Springer Publishing.

Fairholm, M. 2004. Different Perspectives on the Practice of Leadership. *Public Administration Review*, 64(5): 577-590.

Fairhurst, G. T. 2009. Considering context in discursive leadership research. *Human Relations*, 62(11): 1607-1633.

Fealy, G. 2004. 'The good nurse': visions and values in images of the nurse. *Journal of Advanced Nursing*, 46(6): 649-656.

Ferlie, E., & Fitzgerald, L. 2002. The Sustainability of the New Public Management in the UK. In K. McLaughlin, S. Osborne, & E. Ferlie (Eds.), *New Public Management: Current trends and future prospects*: 341-353. London: Routledge.

Ferlie, E., Fitzgerald, L., Wood, M., & Hawkins, C. 2005. The Nonspread of Innovations: The mediating role of professionals. *Academy of Management Journal*, 48(1): 117-134.

Ferlie, E., & Geraghty, K. 2005. Professionals in Public Services Organisations: Implications for Public Sector 'Reforming'. In E. Ferlie, C. Pollitt, & L. E. Lynn Jr (Eds.), *The Oxford Handbook of Public Management*. Oxford: Oxfrod University Press.

Ferlie, E., Hartley, J., & Martin, S. 2003. Changing Public Service Organizations: Current Perspectives and Future Prospects. *British Journal of Management*, 14(s1): S1-S14.

Ferlie, E., & Pettigrew, A. 1996. Managing Through Networks: Some Issues and Implications for the NHS. *British Journal of Management*, 7(1).

Ferlie, E., & Steane, P. 2002. Changing developments in NPM. *International Journal of Public Administration*, 25(12): 1459.

Fernandez, S. 2005. Developing and Testing an Integrative Framework of Public Sector Leadership: Evidence from the Public Education Arena. *J Public Adm Res Theory*, 15(2): 197-217.

Fielding, K. S., & Hogg, M. A. 1997. Social Identity, Self Categorization, and Leadership: A Field Study of Small Interactive Groups. *Group Dynamics, Theory, Research and Practice*, 1(1): 39-51.

Finn, R., Currie, G., & Martin, G. 2010. Team Work in Context: Institutional Mediation in the Public-service Professional Bureaucracy. *Organization Studies*, 31(8): 1069-1097.

Fitzpatrick, J. M., While, A. E., & Roberts, J. D. 1996. Key influences on the professional socialisation and practice of students undertaking different preregistration nurse education programmes in the United Kingdom. *International Journal of Nursing Studies*, 33(5): 506-518.

Fleetwood, S. 2005. Ontology in Organization and Management Studies: A Critical Realist Perspective. *Organization*, 12(2): 197-222.

Flynn, R. 2004. 'Soft Bureacracy', Governmentality and Clinical Governance: Theoretical Approaches to Emergen Policy. In A. Gray, & S. Harrison (Eds.), *Governing Medicine: THeory and Practice*. Berkshire: Open University Press.

Foddy, M., & Smithson, M. 1999. Can Gender Inequalities Be Eliminated? *Social Psychology Quarterly*, 62(4): 307-324.

Fontana, A., & Frey, J. 2003. The Interview: From structured questions to negotiated text. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials*, 2nd ed.: 61-106. London: Sage.

Forbes, T. O. M., & Hallier, J. 2006. Social identity and self-enactment strategies: adapting to change in professional–manager relationships in the NHS. *Journal of Nursing Management*, 14(1): 34-42.

Ford, J., & Harding, N. 2007. Move over management, we are all leaders now. *Management Learning*, 38(5): 475-493.

Ford, J., Harding, N., & Learmonth, M. 2008. *Leadership as Identity*. Hampshire: Palgrave Macmillan.

Francis, R. 2010. Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust: January 2005 - March 2009. London.

Frederickson, H. 1996. Comparing the Reinventing Government Movement with the New Public Administration. *Public Administration Review*, 56(3): 263-270.

Frederickson, H. 2005. Whatever Happened to Public Administration? Governance, governance everywhere. In E. Ferlie, C. Pollitt, & L. E. Lynn Jr (Eds.), *The Oxford Handbook of Public Management*: 282-304. Oxford: Oxford University Press.

Freidson, E. 1988. *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. London: University of Chicago Press.

Friedrich, T. L., Vessey, W. B., Schuelke, M. J., Ruark, G. A., & Mumford, M. D. 2009. A framework for understanding collective leadership: The selective utilization of leader and team expertise within networks. *The Leadership Quarterly*, 20(6): 933-958.

Fry, L., & Kriger, M. 2009. Towards a theory of being-centered leadership: Multiple levels of being as context for effective leadership. *Human Relations*, 62(11): 1667-1696.

Garsten, C. 1999. Betwixt and between: Temporary Employees as Liminal Subjects in Flexible Organizations. *Organization Studies*, 20(4): 601-617.

Gerson, K., & Horowitz, R. 2002. Observation and Interviewing: Options and choices in qualitative research. In T. May (Ed.), *Qualitative Research in Action*. London: Sage.

Gibbs, G. 2007. *Analysing Qualitative Data*. London: Sage.

Giessner, S. R., van Knippenberg, D., & Sleebos, E. 2009. License to fail? How leader group prototypicality moderates the effects of leader performance on perceptions of leadership effectiveness. *The Leadership Quarterly*, 20(3): 434-451.

Gjerberg, E., & Kjølsrød, L. 2001. The doctor-nurse relationship: how easy is it to be a female doctor co-operating with a female nurse? *Social Science & Medicine*, 52(2): 189-202.

Gobo, G. 2007. Sampling, representativeness and generalizability. In C. Seale, G. Gobo, J. Gubrium, & D. Silverman (Eds.), *Qualitative Research in Practice*: 405-426. London: Sage.

Goddard, M., & Mannion, R. 2006. Decentralising the NHS: rhetoric, reality and paradox. *Journal of Health, Organisation and Management*, 20: 67-73.

Goffman, E. 1959. *The Presentation of Self in Everyday Life.* New York: Doubleday Inc.

Goodrick, E., & Reay, T. 2010. Florence Nightingale Endures: Legitimizing a New Professional Role Identity. *Journal of Management Studies*, 47(1): 55-84.

Goodsell, C. 2004. *The Case for Bureacracy: A Public Administration Polemic*. Washington DC: CQ.

Goodwin, J., & Horowitz, R. 2002. Introduction: The Methodological Strengths and Dilemmas of Qualitative Sociology. *Qualitative Sociology*, 25: 33-47.

Graham, I. 2010. The search for the discipline of nursing. *Journal of Nursing Management*, 18(4): 355-362.

Gray, A., & Harrison, S. (Eds.). 2004. *Governing Medicine: Theory and Practice*. Berkshire: Open University Press.

Grey, C. 1999. 'We Are All Managers Now'; 'We Always Were': On the Development and Demise of Management. *Journal of Management Studies*, 36(5): 561-585.

Griffiths, L., & Hughes, D. 2000. Talking contracts and taking care: managers and professionals in the British National Health Service internal market. *Social Science and Medicine*, 51: 209-222.

Griffiths, R. 1983. *National Health Service Management Inquiry Report*. London: HMSO.

Grint, K. 2005. Problems, problems, problems: The social construction of 'leadership'. *Human Relations*, 58(11): 1467-1494.

Gronn, P. 2002. Distributed leadership as a unit of analysis. *The Leadership Quarterly*, 13(4): 423-451.

Gruening, G. 2001. Origin and theoretical basis of new public management. *International Public Management Journal*, 4: 1-25.

Guba, E. G., & Lincoln, Y. S. 1994. Competing paradigms in qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*: 105-117. UK: Sage, Thousand Oaks.

Gunz, H., & Gunz, S. 2007. Hired professional to hired gun: An identity theory approach to understanding the ethical behaviour of professionals in non-professional organizations. *Human Relations*, 60(6): 851-887.

Hadley, M. B., Blum, L. S., Mujaddid, S., Parveen, S., Nuremowla, S., Haque, M. E., & Ullah, M. 2007. Why Bangladeshi nurses avoid [`]nursing': Social and structural factors on hospital wards in Bangladesh. *Social Science & Medicine*, 64(6): 1166-1177.

Hall, P. 2005. Interprofessional teamwork: professional cultures as barriers. *Journal of Interprofessional Care*, 19 Suppl 1: 188-196.

Hall, R. J., & Lord, R. G. 1995. Multi-level information-processing explanations of followers' leadership perceptions. *The Leadership Quarterly*, 6(3): 265-287.

Haque, M. S. 2001. The Diminishing Publicness of Public Service under the Current Mode of Governance. *Public Administration Review*, 61: 65-82.

Harris, A. 2007. Distributed leadership: conceptual confusion and empirical reticence. *International Journal of Leadership in Education: Theory and Practice*, 10(3): 315 - 325.

Harrison, S. 2004. Medicine and Management: Autonomy and Authority in the National Health Service. In A. Gray, & S. Harrison (Eds.), *Governing Medicine: Theory and Practice*. Berkshire: Open University Press.

Hart, C. 2004. *Nurses and Politics: The Impact of Power and Practice*. Hampshire: Palgrave Macmillan.

Hartley, J., & Allison, M. 2000. The Role of Leadership in the Modernization and Improvement of Public Services. *Public Money & Management*, 20: 35-40.

Haslam, S. A. 2004. *Psychology in Organizations: The Social Identity Approach* (2nd ed.). London: Sage.

Haslam, S. A., Ellemers, N., Reicher, S., Reynolds, K. J., & Schmitt, M. 2010. The Social Identity Perspective Today: An Overview of its Defining Ideas. In T. Postmes, & N. Branscombe (Eds.), *Rediscovering Social Identity: Key Readings*. East Sussex: Psychology Press.

Haslam, S. A., Oakes, P. J., Reynolds, K. J., & Turner, J. C. 1999. Social Identity Salience and the Emergence of Stereotype Consensus. *Personality and Social Psychology Bulletin*, 25(7): 809-818.

Haslam, S. A., & Platow, M. J. 2001. The Link between Leadership and Followership: How Affirming Social Identity Translates Vision into Action. *Personality and Social Psychology Bulletin*, 27(11): 1469-1479.

Haslam, S. A., Reicher, S., & Platow, M. 2011. *The New Psychology of Leadership: Identity, Influence and Power*. New York: Psychology Press.

Hean, S., Macleod Clark, J., Adams, K., & Humphris, D. 2006. Will opposites attract? Similarities and differences in students' perceptions of the stereotype profiles of other health and social care professional groups. *Journal of Interprofessional Care*, 20(2): 1-20.

Heck, R., & Hallinger, P. 2010. Testing a longitudinal model of distributed leadership effects on school improvement. *The Leadership Quarterly* 21(5): 867-885

Heifetz, R., Grashow, A., & Linsky, M. 2009. Leadership in a (Permanent) Crisis. *Harvard Business Review*, 87(11): 126-126.

Hemsley-Brown, J., & Foskett, N. H. 1999. Career desirability: young people's perceptions of nursing as a career. *Journal of Advanced Nursing*, 29: 1342-1350.

Henderson, V. 2006. The concept of nursing*. *Journal of Advanced Nursing*, 53(1): 21-31.

Heracleous, L., & Hendry, J. 2000. Discourse and the study of organization: Toward a structurational perspective. *Human Relations*, 53(10): 1251-1286.

Hewison, A., & Griffiths, M. 2004. Leadership development in health care: a word of caution. *Journal of Health, Organisation and Management*, 18: 464-473.

Hiller, N. J., Day, D. V., & Vance, R. J. 2006. Collective enactment of leadership roles and team effectiveness: A field study. *The Leadership Quarterly*, 17(4): 387-397.

Hirst, G., Mann, L., Bain, P., Pirola-Merlo, A., & Richver, A. 2004. Learning to lead: the development and testing of a model of leadership learning. *The Leadership Quarterly*, 15(3): 311-327.

Hofstede, G., Harris Bond, M., & Luk, C.-l. 1993. Individual Perceptions of Organizational Cultures: A Methodological Treatise on Levels of Analysis. *Organizational Studies*, 14(4): 483-503.

Hogg, M. A. 2001a. Social Identification, Group Prototypicality, and Emergent Leadership. In M. A. Hogg, & L. D. Terry (Eds.), *Social Identity Processes in Organizational Contexts*: 197-212. Sussex: Psychology Press.

Hogg, M. A. 2001b. A Social Identity Theory of Leadership. *Personality and Social Psychology Review*, 5(3): 184-200.

Hogg, M. A., Fielding, K. S., Johnson, D., Masser, B., Russell, E., & Svensson, A. 2006. Demographic category membership and leadership in small groups: A social identity analysis. *The Leadership Quarterly*, 17(4): 335-350.

Hogg, M. A., Hains, S. C., & Mason, I. 1998. Identification and leadership in small groups: Salience, frame of reference, and leader stereotypicality effects on leader evaluations. *Journal of Personality and Social Psychology*, 75(5): 1248-1263.

Hogg, M. A., Martin, R., & Weeden, K. 2003. Leader-member relations and social identity. In D. van Knippenberg, & M. A. Hogg (Eds.), *Leadership and Power - Identity processes in groups and organizations*: 18-33. London: Sage.

Hogg, M. A., & Terry, L. D. 2000. Social Identity and Self Categorization Processes in Organizational Contexts. *Academy of Management Review*, 25(1): 121-140.

Hogg, M. A., & Terry, L. D. 2001a. Social Identity Theory and Organizational Processes. In M. A. Hogg, & L. D. Terry (Eds.), *Social Identity Processes in Organizational Contexts*: 1-12. Sussex: Psychology Press.

Hogg, M. A., & Terry, L. D. (Eds.). 2001b. *Social Identity Processes in Organizational Contexts*. Sussex: Psychology Press.

Hoggett, P. 1996. New modes of control in the public service. *Public Administration*, 74(1): 9-32.

Hoggett, P. 2006. Conflict, ambivalence, and the contested purpose of public organizations. *Human Relations*, 59(2): 175-194.

Hood, C. 1974. Administrative Disease: Some Types of Dysfunctionality in Administration. *Public Administration*, 52(4): 439-454.

Hood, C. 1991. A Public Management for All Seasons? *Public Administration*, 69(1): 3-19.

Hood, C. 2005. Public Management: The word, the movement, the science. In E. Ferlie, C. Pollitt, & L. E. Lynn Jr (Eds.), *The Oxford Handbook of Public Management*: 7-26. Oxford: Oxford University Press.

Hooijberg, R., & Choi, J. 2000. Which leadership roles matter to whom? an examination of rater effects on perceptions of effectiveness. *The Leadership Quarterly*, 11(3): 341-364.

Hooijberg, R., Hunt, J. G., & Dodge, G. E. 1997. Leadership Complexity and Development of the leaderplex Model. *Journal of Management*, 23(3): 375-408.

Hoque, K., Davis, S., & Humphreys, M. 2004. Freedom to do What you are Told: Senior Management Team Autonomy in an NHS Acute Trust. *Public Administration*, 82(2): 355-375.

Howell, J. M., & Shamir, B. 2005. The role of followers in the charismatic leadership process: relationships and their consequences. *Academy of Management Review*, 30(1): 96-112.

Howell, J. P., Bowen, D. E., Dorfman, P. W., Kerr, S., & Podsakoff, P. M. 1990. Substitutes for Leadership: Effective Alternatives to Ineffective Leadership. *Organizational Dynamics*, 19(1): 20-38.

Hughes, D. 1988. When nurse knows best: some aspects of nurse/doctor interaction in a casualty department. *Sociology of Health & Illness*, 10(1): 1-22.

Hughes, O. 2003. *Public Management and Administration: An Introduction* (3rd Edition ed.). Hampshire: Palgrave Macmillan.

Hunt, J. G. 1999. Transformational/charismatic leadership's tranformation of the field: An historical essay. *The Leadership Quarterly*, 10(2): 129-144.

Hunt, J. G., & Dodge, G. E. 2000. Leadership déjà vu all over again. *The Leadership Quarterly*, 11(4): 435-458.

Hunter, D. J. 1984. NHS Management: Is Griffiths the Last Quick Fix? . *Public Administration*, 62(1): 91-94.

Hunter, D. J. 1996. The changing roles of health care personnel in health and health care management. *Social Science & Medicine*, 43(5): 799-808.

Ibarra, H. 1999. Provisional Selves: Experimenting with Image and Identity in Professional Adaptation. *Administrative Science Quarterly*, 44(4): 764-791.

Ibarra, H., & Barbulescu, R. 2010. Identity as Narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions *Academy of Management Review*, 35(1): 135-154.

Iedema, R., Degeling, P., Braithwaite, J., & White, L. 2004. 'It's an Interesting Conversation I'm Hearing': The Doctor as Manager. *Organization Studies*, 25: 15-33.

Institute for Innovation and Improvement. 2005. *NHS Leadership Qualities Framework.* London: NHS.

Institute for Innovation and Improvement. 2010. *Medical Leadership Competency Framework*. London: NHS

Jackson, J. W., & Smith, E. R. 1999. Conceptualizing Social Identity: A New Framework and Evidence for the Impact of Different Dimensions. *Personality and Social Psychology Bulletin*, 25(1): 120-135.

Jackson, P. M. 2001. Public Sector Added Value: Can Bureaucracy Deliver? *Public Administration*, 79(1): 5.

Javidan, M., & Waldman, D. A. 2003. Exploring Charismatic Leadership in the Public Sector: Measurement and Consequences. *Public Administration Review*, 63(2): 229-242.

Johns, G. 2006. The essential impact of context on organizational behaviour. *Academy of Management Review*, 31(2): 386-408.

Johnson, P. 1998. Analytic Induction. In G. Symon, & C. Cassell (Eds.), *Qualitative Methods and Analysis in Organizational Research: A practical guide*: 28-50. London: Sage.

Jost, J., & Elsbach, K. 2001. How Status and Power Differences Erode Personal and Social Identities at Work: A system justification critique of organizational applications of social identity theory. In M. A. Hogg, & L. D. Terry (Eds.), *Social Identity Processes in Organizational Contexts*: 181-196. Sussex: Psychology Press.

Judge, T. A., Piccolo, R. F., & Kosalka, T. 2009. The bright and dark sides of leader traits: A review and theoretical extension of the leader trait paradigm. *The Leadership Quarterly*, 20(6): 855-875.

Jung, D., Yammarino, F. J., & Lee, J. K. 2009. Moderating role of subordinates' attitudes on transformational leadership and effectiveness: A multi-cultural and multi-level perspective. *The Leadership Quarterly*, 20(4): 586-603.

Jung, D. I., Chow, C., & Wu, A. 2003. The role of transformational leadership in enhancing organizational innovation: Hypotheses and some preliminary findings. *The Leadership Quarterly*, 14(4-5): 525-544.

Kakabadse, A., Korac-Kakabadse, N., & Kouzmin, A. 2003. Ethics, values and behaviours: comparison of three case studies examining the paucity of leadership in government. *Public Administration*, 81(3): 477-508.

Kalkhoff, W., & Barnum, C. 2000. The Effects of Status-Organizing and Social Identity Processes on Patterns of Social Influence. *Social Psychology Quarterly*, 63(2): 95-115.

Kan, M. M., & Parry, K. W. 2004. Identifying paradox: A grounded theory of leadership in overcoming resistance to change. *The Leadership Quarterly*, 15(4): 467-491.

Kaplan, R. S., & Norton, D. R. 2005. The Balanced Scorecard: Measures That Drive Performance. (cover story). *Harvard Business Review*, 83(7/8): 172-180.

Katz, R. 1955. Skills of and Effective Administrator. *Harvard Business Review*, January - February: 33-42.

Keeling, D. 1972. *Management in Government*. London: Allen & Unwin.

Keller, T. 1999. Images of the familiar: Individual differences and implicit leadership theories. *The Leadership Quarterly*, 10(4): 589-607.

Kellerman, B. 2004. Leadership Warts and All. (cover story). *Harvard Business Review*, 82(1): 40-45.

Kelly, S. 2008. Leadership: A categorical mistake? *Human Relations*, 61(6): 763-782.

Kent, T. W. 2005. Leading and managing: it takes two to tango. *Management Decision*, 43: 1010-1017.

Kent, T. W., Crotts, J. C., & Azziz, A. 2001. Four factors of transformational leadership behavior. *Leadership and Organization Development Journal*, 22: 221-229.

Kernaghan, K. 2000. The Post-Bureaucratic Organization and Public Service Values1. *International Review of Administrative Sciences*, 66(1): 91-104.

Kiljn, E. 2005. Networks and Inter-Organisational Management: challenging, steering, evaluation, and the role of public actors in public management. In E. Ferlie, C. Pollitt, & L. E. Lynn Jr (Eds.), *The Oxford Handbook of Public Management*: 257-281. Oxford: Oxford University Press.

Kim, S. 2002. Participative Management and Job Satisfaction: Lessons for Management Leadership. *Public Administration Review*, 62(2): 231.

King, G., Keohane, R., & Verba, S. 1994. *Designing Social Inquiry: Scientific Inference in Qualitative Research*. New Jersey: Princeton University Press.

King, N. 1998. Template Analysis. In G. Symon, & C. Cassell (Eds.), *Qualitative Methods and Analysis in Organizational Research: A practical guide*: 118-134. London: Sage.

Kings Fund. 2012. *Leadership Engagement for Improvement in the NHS: Together We Can.* London: The Kings Fund

Kippist, L., & Fitzgerald, A. 2009. Organisational Professional Conflict and Hybrid Clinician Managers. *Journal of Health Organisation and Management*, 23(6): 642-655.

Klein, K., Dansereau, F., & Hall, R. J. 1994. Levels Issues in Theory Development, Data Collection and Analysis. *Academy of Management Review*, 19(2): 195-229.

Klein, R. 2001. *The New Politics of the NHS* (4th ed.). London: Prentice Hall.

Kort, E. D. 2008. What, after all, is leadership? [`]Leadership' and plural action. *The Leadership Quarterly*, 19(4): 409-425.

Kosmala, K., & Herrbach, O. 2006. The ambivalence of professional identity: On cynicism and jouissance in audit firms. *Human Relations*, 59(10): 1393-1428.

Kotter, J. P. 2001. What Leaders Really Do. *Harvard Business Review*, 79(11): 85-96.

Kotter, P. 1990. *A force for change: How leadership differs from management*. New Jersey: The Free Press.

Kreiner, G. E., Hollensbe, E. C., & Sheep, M. L. 2006. On the edge of identity: Boundary dynamics at the interface of individual and organizational identities. *Human Relations*, 59(10): 1315-1341.

Kreuger, C. 1978. Good Girls - Bad Nurses. In R. Dingwall, & J. McIntosh (Eds.), *Readings in the Sociology of Nursing*: 48-52. London: Churchill Livingstone.

Lane, J.-E. 2002. *New Public Management*. London: Routledge.

LaTendresse, D. 2000. Social Identity and Intergroup Relations Within the Hospital. *Journal of Social Distress and the Homeless*, 9(1): 51-69.

Lawler, J. 2008. Individualization and Public Sector Leadership. *Public Administration*, 86: 21-34.

Lazzari, M. M., Colarossi, L., & Collins, K. S. 2009. Feminists in Social Work. *Affilia*: 348-359.

Learmonth, M. 2005. Doing Things with Words: The Case of 'Management' and 'Administration'. *Public Administration*, 83(3): 617-637.

Lichtenstein, B. B., & Plowman, D. A. 2009. The leadership of emergence: A complex systems leadership theory of emergence at successive organizational levels. *The Leadership Quarterly*, 20(4): 617-630.

Lindgren, M. & Wahlin, N. 2001. Identity Construction Among Boundary-Crossing Individuals. *Scandinavian Journal of Management,* 357-377

Llewellyn, S. 2001. `Two-Way Windows': Clinicians as Medical Managers. *Organization Studies*, 22(4): 593-623.

Lord, R. G., Brown, D. J., Harvey, J. L., & Hall, R. J. 2001a. Contextual constraints on prototype generation and their multilevel consequences for leadership perceptions. *The Leadership Quarterly*, 12(3): 311-338.

Lord, R. G., Brown, D. J., & Harvey, J. L. 2001b. System Constraints on Leadership Perceptions, Behaviour and Influence: An example of connectionist level processes. In M. A. Hogg, & S. Tindale (Eds.), *Blackwell Handbook of Social Psychology: Group Processes*: 283-310. Oxford: Blackwell.

Lord, R. G., Foti, R. J., & De Vader, C. L. 1984. A test of leadership categorization theory: Internal structure, information processing, and leadership perceptions. *Organizational Behavior and Human Performance*, 34(3): 343-378.

Lord, R. G., & Hall, R. J. 2003. Identity, leadership categorization and leadership schema. In D. van Knippenberg, & M. A. Hogg (Eds.), *Leadership and Power - Identity processes in groups and organizations*: 48-64. London: Sage.

Lord, R. G., & Hall, R. J. 2005. Identity, deep structure and the development of leadership skill. *The Leadership Quarterly*, 16(4): 591-615.

Lynn Jr, L. E. 1998. The New Public Management: How to Transform a Theme into a Legacy. *Public Administration Review*, 58(3): 231-237.

Lynn, L. E. 1998. A Critical Analysis of the New Public Management. *International Public Management Journal*, 1: 107-123.

Mackay, L. 1989. *Nursing a Problem*. Milton Keynes: Open University Press.

Maddock, S. 2002. Making modernisation work: New narratives, change strategies and people management in the public sector. *International Journal of Public Sector Management*, 15: 13-43.

Malterud, K. 2001. Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358(9280): 483-488.

Mannion, R. 2011. General practitioner-led commissioning in the NHS: progress, prospects and pitfalls. *British Medical Bulletin*, 97(1): 7-15.

Marion, R., & Uhl-Bien, M. 2001. Leadership in complex organizations. *The Leadership Quarterly*, 12(4): 389-418.

Marshall, C., & Rossman, G. 1999. *Designing Qualitative Research* (3rd ed.). London: Sage.

Marsick, V., & O'Neil, J. 1999. The many faces of Action Learning. *Management Learning*, 30(2): 159-176.

Martin, D. 2009. All new nurses will need to have degrees to work for the NHS (but will it actually benefit patients?, *The Daily Mail*. London.

Martin, G. P., Currie, G., & Finn, R. 2009. Leadership, Service Reform, and Public-Service Networks: The Case of Cancer-Genetics Pilots in the English NHS. *J Public Adm Res Theory*, 19(4): 769-794.

Mason, J. 2002. Qualitative Interviewing: Asking, listening and interpreting In T. May (Ed.), *Qualitative Research in Action*. London: Sage.

Mays, N., & Pope, C. 1995. Qualitative Research: Rigour and qualitative research. *British Medical Journal*(311): 109-112.

McAlearney, A. S. 2006. Leadership development in healthcare: a qualitative study. *Journal of Organizational Behavior*, 27(7): 967-982.

McCartney, W. W., & Campbell, C. R. 2006. Leadership, management, and derailment: A model of individual success and failure. *Leadership and Organization Development Journal*, 27: 190-202.

McGivern, G. & Ferlie, E. 2007. Playing Tick Box Games: Interrelating Defences in Professional Appraisal. *Human Relations,* 60, 1361-1385.

McGivern G. & Fischer, D. 2012. Reactivity and reactions to regulatory transparency in medicine, psychotherapy and counselling. *Social Science & Medicine,* 74, 286-296.

McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. 2003. Horizontal violence: experiences of Registered Nurses in their first year of practice. *Journal of Advanced Nursing*, 42(1): 90-96.

McKenna, H., Keeney, S., & Bradley, M. 2004. Nurse leadership within primary care: the perceptions of community nurses, GPs, policy makers and members of the public. *Journal of Nursing Management*, 12(1): 69-76.

McLean, J. 2005. Management and Leadership: Dispelling the myths. *The British Journal of Administrative Management*, Oct/Nov: 16.

McNulty, T. 2003. Redesigning Public Services: Challenges of Practice for Policy. *British Journal of Management*, 14: S31-S45.

Mead, G. 1934. *Mind, Self and Society* Chicago: University of Chicago Press

Medical Research Council. 2005. *Good Research Practice*. London: MRC

Mehra, A., Smith, B. R., Dixon, A. L., & Robertson, B. 2006. Distributed leadership in teams: The network of leadership perceptions and team performance. *The Leadership Quarterly*, 17(3): 232-245.

Meier, K., & Hill, G. 2005. Bureacracy in the Twenty-First Century. In E. Ferlie, C. Pollitt, & L. E. Lynn Jr (Eds.), *The Oxford Handbook of Public Management*: 51-71. Oxford: Oxford University Press.

Meindl, J., & Ehrlich, S. 1987. The romance of leadership and the evaluation of organizational performance. *Academy of Management Journal*, 30(1): 91-109.

Merkouris, A., Papathanassoglou, E., & Lemonidou, C. 2004. Evaluation of patient satisfaction with nursing care: quantitative or qualitative approach? *International Journal of Nursing Studies*, 41(4): 355-367.

Miers, M. 1999. Nursing Teams and Hierarchies: Nurses Working with Nurses. In G. Wilkinson, & M. Miers (Eds.), *Power and Nursing Practice*: 64-79. Hampshire: Macmillan Press.

Montgomery, K., & Oliver, A. L. 2007. A Fresh Look at How Professions Take Shape: Dual-directed Networking Dynamics and Social Boundaries. *Organization Studies*, 28(5): 661-687.

Moreland, R., Levine, J., & McMinn, J. 2001. Self Categorization and Work Group Socialization. In M. A. Hogg, & L. D. Terry (Eds.), *Social Identity Processes in Organizational Contexts*: 87-100. Sussex: Psychology Press.

Morgan, M., Calan, M., & Manning, N. 1995. *Sociological Approaches to Health and Medicine*. London: Routledge.

Morgeson, F. P., & Hofmann, D. A. 1999. The structure and function of collective constructs: Implications for multilevel research and theory development. *Academy of Management Review*, 24(2): 249-265.

Mumford, M. D., Antes, A. L., Caughron, J. J., & Friedrich, T. L. 2008. Charismatic, ideological, and pragmatic leadership: Multi-level influences on emergence and performance. *The Leadership Quarterly*, 19(2): 144-160.

Murphy, S. E., & Ensher, E. A. 2008. A qualitative analysis of charismatic leadership in creative teams: The case of television directors. *The Leadership Quarterly*, 19(3): 335-352.

Nembhard, I. M., & Edmondson, A. C. 2006. Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior*, 27(7): 941-966.

National Health Service. 2010a. *NHS Staff 1999-2009 (Non-Medical).* Information Centre.

National Health Service. 2010b. *Defining Emerging Leaders.*

National Health Service. 2010c. *Liberating the NHS: Developing the Healthcare Workforce: A consultation on proposals* London: HMSO.

National Health Service. 2010d. *Emerging Leaders. 2010: NHS East Midlands.*

National Health Service. 2012. *NHS Workforce: Summary of Staff in the NHS - Results from September 2011 Census. London:* NHS Information Centre for Health and Social Care.

National Research Ethics Service. 2010. *Ethical Review of Student Research: Guidance for students, supervisors and research ethics committees.* London: National Patient Safety Association.

NHS Leadership Academy. 2011. *Clinical leadership Competency Framework* Coventry: NHS

NHS Leadership Council. 2010a. *Clinical Leadership: Interim Report*. London: NHS.

NHS Leadership Council. 2010b. *First Year: The Foundation 2009-2010.* London: NHS.

Northouse, P. 2007. *Leadership Theory and Practice* (4th Edition ed.). London: Sage.

Nottinghamshire Healthcare NHS Trust. 2010. Invest to Lead 2: Excellence in Quality, Innovation, Productivity and Prevention. Nottingham.

Nursing and Midwifery Council 2010. *Nurse education: Now and in the future*. London: NMC.

Organization for Economic Co-operation and Development. 2001. *Public Sector Leadership for the 21st Century: Executive Summary*: OECD.

Offermann, L. R., Kennedy, J. K., & Wirtz, P. W. 1994. Implicit leadership theories: Content, structure, and generalizability. *The Leadership Quarterly*, 5(1): 43-58.

Öhlén, J., & Segesten, K. 1998. The professional identity of the nurse: concept analysis and development. *Journal of Advanced Nursing*, 28(4): 720-727.

Oldmeadow, J., & Fiske, S. 2010. Social Status and the Pursuit of Positive Social Identity. *Group Processes and Intergroup Relations*, 13(4): 425-444.

Oldmeadow, J., Platow, M., Foddy, M., & Anderson, D. 2003. Self-Categorization, Status and Social Influence. *Social Psychology Quarterly*, 66(2): 138-152.

Olsen, J. P. 2006. Maybe It Is Time to Rediscover Bureaucracy. *Journal of Public Administration Research and Theory*, 16: 1-24.

Olson, T. 1997. Ordered to Care?: Professionalisation, Gender and the Language of Training, 1915-37. In A. M. Rafferty, J. Robinson, & R. Elkan (Eds.), *Nursing History and the Politics of Welfare*: 150-163. London: Routledge.

O'Reilly, D., & Reed, M. 2010. 'Leaderism': An Evolution of Managerialism in UK Public Service Reform. *Public Administration*, 88(4): 960-978.

O'Reilly, D., & Reed, M. 2011. The Grit in the Oyster: Professionalism, Managerialism and Leaderism as Discourses of UK Public Services Modernization. *Organization Studies*, 32(8): 1079-1101.

Osborn, R. N., Hunt, J. G., & Jauch, L. R. 2002. Toward a contextual theory of leadership. *The Leadership Quarterly*, 13(6): 797-837.

Osborne, D., & Gaebler, T. 1992. *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector from Schoolhouse to Statehouse, City Hall to the Pentagon*. Reading, MA: Addison-Weasley.

Osborne, S., & McLaughlin, K. 2002. The New Public Management in Context. In K. McLaughlin, S. Osborne, & E. Ferlie (Eds.), *New Public Management: Curent trends and future prospects*: 7-14. London: Routledge.

Parry, K. W. 1998. Grounded theory and social process: A new direction for leadership research. *The Leadership Quarterly*, 9(1): 85-105.

Pearce, C. L. 2006. The future of leadership: combining vertical and shared leadership to transform knowledge work. *Engineering Management Review, IEEE*, 34(1): 103-103.

Pearce, C. L., & Conger, J. A. (Eds.). 2003. *Shared Leadership: Reframing the hows and whys of leadership*. London: Sage.

Pearce, C. L., Conger, J. A., & Locke, E. A. 2007. Shared leadership theory. *The Leadership Quarterly*, 18(3): 281-288.

Pearce, C. L., Manz, C. C., & Sims Jr, H. P. 2008. The roles of vertical and shared leadership in the enactment of executive corruption: Implications for research and practice. *The Leadership Quarterly*, 19(3): 353-359.

Pearce, C. L., & Sims Jr, H. P. 2002. Vertical versus shared leadership as predictors of the effectiveness of change management teams: An examination of aversive, directive, transactional, transformational and empowering leader behaviors. *Group Dynamics, Theory, Research and Practice*, 6(2): 172-197.

Performance Innovation Unit. 2001. *Strengthening leadership in the Public Sector: A research study by the PIU*: Performance and Innovation Unit.

Platow, M., Haslam, A., Foddy, M., & Grace, D. 2003. Leadership as the outcome of self-categorization processes. In D. van Knippenberg, & M. A. Hogg (Eds.), *Leadership and Power - Identity processes in groups and organizations*: 34-47. London: Sage.

Platow, M. J., & van Knippenberg, D. 2001. A Social Identity Analysis of Leadership Endorsement: The Effects of Leader Ingroup Prototypicality and Distributive Intergroup Fairness. *Personality and Social Psychology Bulletin*, 27(11): 1508-1519.

Pollitt, C. 1993. *Managerialism and the Public Services*. Oxford: Blackwell.

Pollock, A. 2005. *NHS Plc: The Privatisation of Our HealthCare*. London: Verson.

Pond, C. 2006. Leadership in the Allied Health Professions In R. Jones, & F. Jenkins (Eds.), *Managing and Leading in the Allied Health Professions*: 100-116. Oxon: Radcliffe Publishing.

Porter, L. W., & McLaughlin, G. B. 2006. Leadership and the organizational context: Like the weather? *The Leadership Quarterly*, 17(6): 559-576.

Porter, S. 1992. Women in a women's job: the gendered experience of nurses. *Sociology of Health & Illness*, 14(4): 510-527.

Porter, S. 2007. Validity, trustworthiness and rigour: reasserting realism in qualitative research. *Journal of Advanced Nursing*, 60(1): 79-86.

Potter, G. 2000. *The Philosophy of Social Science: New Perspectives*. Essex: Pearson Education Limited.

Pratt, M. 2001. Social Identity Dynamics in Modern Organizations: An Organizational Psychology/Organizational Behaviour Perspective. In M. A. Hogg, & L. D. Terry (Eds.), *Social Identity Processes in Organizational Contexts*: 13-30. Sussex: Psychology Press.

Pratt, M., & Foreman, P. 2000. Classifying Managerial Responses to Multiple Organizational Identities. *Academy of Management Review*, 25(1): 18-42.

Pratt, M., & Rafaeli, A. 1997. Organizational Dress as a Symbol of Multilayered Social Identities. *Academy of Management Journal*, 40(4).

Pratt, M. G., Rockmann, K. W., & Kaufmann, J. B. 2006. Constructing Professional Identity: The Role of Work and Identity Learning Cycles in the Customization of Identity Among Medical Residents. *The Academy of Management Journal ARCHIVE*, 49(2): 235-262.

Pullen, A., & Simpson, R. 2009. Doing difference in feminized work: Men, otherness and social practice. *Human Relations*, 62(4): 561-587.

Rapley, T. 2007. Interviews. In C. Seale, G. Gobo, J. Gubrium, & D. Silverman (Eds.), *Qualitative Research Practice*: 15-33. London: Sage.

Raz, A. E., & Fadlon, J. 2006. Managerial Culture, Workplace Culture and Situated Curricula in Organizational Learning. *Organization Studies*, 27(2): 165-182.

Royal College of Nursing. 2006. *Informed Consent in Health and Social Care Research: RCN Guidance for Nurses.* London: RCN

Royal College of Nursing. 2009. *Research Ethics: RCN Guidance for Nurses*. London: RCN

Reeves, S., Macmillan, K., & Van Soeren, M. 2010. Leadership of interprofessional health and social care teams: a socio-historical analysis. *Journal of Nursing Management*, 18: 258-264.

Regine, B., & Lewin, R. 2000. Leading at the Edge: How Leaders Influence Complex Systems. *Emergence*, 2(2): 5-23.

Ridgeway, C. 2003. Status characteristics and leadership. In D. van Knippenberg, & M. A. Hogg (Eds.), *Leadership and Power - Identity processes in groups and organizations*: 65-78. London: Sage.

Roberts, L. 2005. Changing Faces: Professional Imange Construction in Diverse Organizational Settings. *Academy of Management Review*, 30(4): 685-711.

Rolfe, G. 2006. Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3): 304-310.

Ryan, R., & Deci, E. 2003. On Assimilating Identities to the Self: A self-determination theory perspective on internalisation and integrity within cultures. In M. Leary, & J. Tangney (Eds.), *The Handbook of Self and Identity*: 253-274. London: The Guildford Press.

Salvage, J. 2006. More than a makeover is needed to improve nursing's image. *Journal of Advanced Nursing*, 54(3): 259-260.

Schalbe, M. & Mason-Schrock, D. (1996) Identity Work as Group Process. *Advances in Group Processes* 13: 113-147

Schein, E. 1978. *Career Dyanmics: Matching Individual and Organizational Needs.* Reading: Addison-Wesley

Schlenker, B. 2003. Self-Presentation. In M. Leary, & J. Tangney (Eds.), *The Handbook of Self and Identity*: 492-518. London: The Guildford Press.

Schneider, M., & Somers, M. 2006. Organizations as complex adaptive systems: Implications of Complexity Theory for leadership research. *The Leadership Quarterly*, 17(4): 351-365.

Schriesheim, C. A., & Cogliser, C. C. 2009. Construct validation in leadership research: Explication and illustration. *The Leadership Quarterly*, 20(5): 725-736.

Schriesheim, C. A., Wu, J. B., & Scandura, T. A. 2009. A meso measure? Examination of the levels of analysis of the Multifactor Leadership Questionnaire (MLQ). *The Leadership Quarterly*, 20(4): 604-616.

Seale, C. 1999. Quality in Qualitative Research. *Qualitative Inquiry*, 5(4): 465-478.

Seale, C., & Silverman, D. 1997. Ensuring rigour in qualitative research. *European Journal of Public Health*, 7(4): 379-384.

Sehested, K. 2002. How New Public Management reforms challenge the roles of Professionals. *International Journal of Public Administration*, 25(12): 1513 - 1537.

Seidman, I. 1998. *Interviewing as Qualitative Research* (2nd ed.). London: Teachers College Press.

Seltzer, J., & Bass, B. M. 1990. Transformational Leadership: Beyond Initiation and Consideration. *Journal of Management*, 16(4): 693-703.

Shortell, S. M. 1974. Occupational prestige differences within the medical and allied health professions. *Social Science & Medicine (1967)*, 8(1): 1-9.

Siggelkow, N. 2007. Persuasion with case studies. *Academy of Management Journal*, 50(1): 20-24.

Silverman, D. 2003. Analysing Talk and Text. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Collecting and Interpreting Qualitative Materials*, 2nd ed.: 340-362. London: Sage.

Silvia, C., & McGuire, M. 2010. Leading public sector networks: An empirical examination of integrative leadership behaviors. *The Leadership Quarterly*, 21(2): 264-277.

Sims, D. 2003. Between the Millstones: A Narrative Account of the Vulnerability of Middle Managers‚Äô Storying. *Human Relations*, 56(10): 1195-1211.

Slay, H. & Smith, D. 2011. Professional Identity Construction: Using narrative to understand the negotiation of professional and stigmatized cultural identities *Human Relations* 64(1): 85-107

Smith, D. 2002. Institutional ethnography. In T. May (Ed.), *Qualitative Research in Action*. London: Sage.

SØRensen, E. E., Delmar, C., & Pedersen, B. D. 2011. Leading nurses in dire straits: head nurses' navigation between nursing and leadership roles. *Journal of Nursing Management*, 19(4): 421-430.

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. 2003. *Quality in Qualitative Evaluation: A framework for assessing research evidence - a quality framework.* London: National Centre for Social Research

Stewart, J., & Walsh, K. 1992. Change in the management of public services. *Public Administration*, 70(4): 499-518.

Steyrer, J. 1998. Charisma and the Archetypes of Leadership. *Organization Studies*, 19(5): 807-828.

Strange, J. M., & Mumford, M. D. 2002. The origins of vision: Charismatic versus ideological leadership. *The Leadership Quarterly*, 13(4): 343-377.

Stryker, S. & Burke, P. 2000. The Past, Present, and Future of an Identity Theory. *Social Psychology Quarterly,* 63(4); 284-297

Sturdy, A., Schwarz, M., & Spicer, A. 2006. Guess who's coming to dinner? Structures and uses of liminality in strategic management consultancy. *Human Relations*, 59(7): 929-960.

Sveningsson, S., & Alvesson, M. 2003. Managing Managerial Identities: Organizational Fragmentation, Discourse and Identity Struggle. *Human Relations*, 56(10): 1163-1193.

Svensson, G., & Wood, G. 2005. Sustainable components of leadership effectiveness in organizational performance. *Journal of Management Development*, 25(6): 522-534.

Svensson, R. 1996. The interplay between doctors and nurses—a negotiated order perspective. *Sociology of Health & Illness*, 18(3): 379-398.

Tajfel, H. 1978. Interindividual behaviour and intergroup behaviour In H. Tajfel (Ed.), *Differentiation Between Social Groups: Studies in the Social Psychology of Group Relations*: 27-60. London: Academic Press.

Tajfel, H. 1981. Social Stereotypes and Social Groups. In J. C. Turner, & H. Giles (Eds.), *Intergroup Behaviour*: 144-167. Oxford: Blackwell.

Tajfel, H. 2010. Social Identity and Intergroup Behavior. In T. Postmes, & N. Branscombe (Eds.), *Rediscovering Social Identity: Key Readings*. East Sussex: Psychology Press.

Takase, M., Kershaw, E., & Burt, L. 2002. Does public image of nurses matter? *Journal of professional nursing : official journal of the American Association of Colleges of Nursing*, 18(4): 196-205.

Tejeda, M. J., Scandura, T. A., & Pillai, R. 2001. The MLQ revisited: psychometric properties and recommendations. *The Leadership Quarterly*, 12(1): 31-52.

Tellis-Nayak, M., & Tellis-Nayak, V. 1984. Games that professionals play: The social psychology of physician-nurse interaction. *Social Science & Medicine*, 18(12): 1063-1069.

Thomas, R., & Linstead, A. 2002. Losing the Plot? Middle Managers and Identity. *Organization*, 9(1): 71-93.

Thompson, G., & Vecchio, R. P. 2009. Situational leadership theory: A test of three versions. *The Leadership Quarterly*, 20(5): 837-848.

Tice, D., & Wallace, H. 2003. The Reflected Self: Creating yourself as (you think) others see you. In M. Leary, & J. Tangney (Eds.), *Handbook of Self and Identity* 91-105. London: The Guildford Press.

Tierney, W. G. 1996. Leadership and postmodernism: On voice and the qualitative method. *The Leadership Quarterly*, 7(3): 371-383.

Timmins, N. 2012. *Never Again? The Story of the Health and Social Care Act 2012. A Study in Coalition Government and Decision Making* London: The Kings Fund

Torpman, J. 2004. The differentiating function of modern forms of leadership. *Management Decision*, 42: 892-906.

Torrance, H. 2008. Building Confidence in Qualitative Research: Engaging the Demands of Policy. *Qualitative Inquiry*, 14(4): 507-527.

Trottier, T., Van Wart, M., & Wang, X. 2008. Examining the Nature and Significance of Leadership in Government Organizations. *Public Administration Review*, 68: 319-333.

Turner, J. C. 1987. *Rediscovering the Social Group: A Self-Categorization Theory*. Oxford: Basil Blackwell Ltd.

Uhl-Bien, M., & Marion, R. 2009. Complexity leadership in bureaucratic forms of organizing: A meso model. *The Leadership Quarterly*, 20(4): 631-650.

Uhl-Bien, M., Marion, R., & McKelvey, B. 2007. Complexity Leadership Theory: Shifting leadership from the industrial age to the knowledge era. *The Leadership Quarterly*, 18(4): 298-318.

Van Der Vegt, G., & Bunderson, J. S. 2006. Learning and performance in multidisciplinary teams: the importance of collective team identification. *Academy of Management Journal*, 48(3): 532-547.

van Knippenberg, D., van Knippenberg, B., De Cremer, D., & Hogg, M. A. 2004. Leadership, self, and identity: A review and research agenda. *The Leadership Quarterly*, 15(6): 825-856.

Van Wart, M. 2003. Public-Sector Leadership Theory: An Assessment. *Public Administration Review*, 63(2): 214-228.

Waldman, D. A., Lituchy, T., Gopalakrishnan, M., Laframboise, K., Galperin, B., & Kaltsounakis, Z. 1998. A qualitative analysis of leadership and quality improvement. *The Leadership Quarterly*, 9(2): 177-201.

Wallace, J. E. 1995. Organizational and Professional Commitment in Professional and Nonprofessional Organizations. *Administrative Science Quarterly*, 40(2): 228-255.

Waring, J., & Currie, G. 2009. Managing Expert Knowledge: Organizational Challenges and Managerial Futures for the UK Medical Profession. *Organization Studies*, 30(7): 755-778.

Warwick, P. 2007. Back to the future in NHS reform. *Journal of Health, Organisation and Management*, 21: 194-204.

Washbush, J. B. 2005. There is no such thing as leadership, revisited. *Management Decision*, 43: 1078-1085.

Watson, T. J. 2008. Managing Identity: Identity Work, Personal Predicaments and Structural Circumstances. *Organization*, 15(1): 121-143.

Watson, T. J. 2009. Narrative, life story and manager identity: A case study in autobiographical identity work. *Human Relations*, 62(3): 425-452.

Waugaman, W. R., & Lohrer, D. J. 2000. From nurse to nurse anesthetist: The influence of age and gender on professional socialization and career commitment of advanced practice nurses. *Journal of Professional Nursing*, 16(1): 47-56.

Weber, M. 1947. *The Theory of Social and Economic Organisation* (A. Henderson, & T. Parsons, Trans.). London: Collier Macmillan Publishers.

Wells, G. 2007. Who we become depends on the company we keep and on what we do and say together *International Jounral of Educational Research* 46: 100-103

Whittaker, E., & Olesen, V. 1978. The faces of Florence Nightingale: Functions of the heroine legend in an occupational sub-culture. In R. Dingwall, & J. McIntosh (Eds.), *Readings in the Sociology of Nursing*: 19-35. London: Churchill Livingstone.

Whittock, M., & Leonard, L. 2003. Stepping outside the stereotype. A pilot study of the motivations and experiences of males in the nursing profession. *Journal of Nursing Management*, 11(4): 242-249.

Wicks, D. 1998. *Nurses and Doctors at Work: Rethinking Professional Boundaries*. Buckingham: Open University Press.

Wilkinson, M. J. 1995. Love is not a marketable commodity: new public management in the British National Health Service. *Journal of Advanced Nursing*, 21(5): 980-987.

Williams, C. 1992. The Glass Escalator: Hidden Advantages for Men in the "Female" Professions. *Social Problems*, 39(3): 253-267.

Williams, K. 1978. Ideologies of Nursing: Their meanings and implications. In R. Dingwall, & J. McIntosh (Eds.), *Readings in the Sociology of Nursing*: 36-44. London: Churchill Livingstone.

Williams, M. 2002. Generalization in interpretive research. In T. May (Ed.), *Qualitative Research in Action*. London: Sage.

Williams, S. 2004. *Literature Review: Evidence of the contribution leadership development for professional groups makes in driving their organisations forward.* NHS Leadership Centre.

Wilson, F. 2003. *Organizational Behaviour and Gender* (2nd ed.). Hants: Ashgate Publishing.

Witman, Y., Smid, G. A. C., Meurs, P. L., & Willems, D. L. 2011. Doctor in the lead: balancing between two worlds. *Organization*, 18(4): 477-495.

Woodward, V. 1997. Professional caring: a contradiction in terms? *Journal of Advanced Nursing*, 26(5): 999-1004.

Yin, R. 2003. *Case Study Research: Design and Methods* (3rd ed.). London: Sage.

Yukl, G. 1989. Managerial Leadership: A Review of Theory and Research. *Journal of Management*, 15(2): 251-289.

Yukl, G. 1999. An evaluation of conceptual weaknesses in transformational and charismatic leadership theories. *The Leadership Quarterly*, 10(2): 285-305.

Yukl, G. 2006. *Leadership in Organisations* (6th Edition ed.). New Jersey: Pearson.

Yukl, G. 2008. How leaders influence organizational effectiveness. *The Leadership Quarterly*, 19(6): 708-722.

Zaccaro, S. J., Rittman, A. L., & Marks, M. A. 2001. Team leadership. *The Leadership Quarterly*, 12(4): 451-483.

Zaleznik, A. 2004. Managers and Leaders: Are They Different? *Harvard Business Review*, 82(1): 74-81.

APPENDIX

Participant Information Sheet

Invitation to take part

We would like to invite you to be interviewed as part of our research study. Before you decide whether to take part please take a few moments to read this information sheet. Should you have any questions please do not hesitate to ask.

What is the study about?

This study sets out to evaluate leadership development programs within the NHS, with a particular focus on nurses and allied health professionals. It is hoped that the findings will add to theories of leadership in the health service and provide an insight into the difficulties of effective clinical leadership.

Why have I been invited?

You recently took part in a leadership development program run by Nottinghamshire Healthcare NHS Trust. You are also a Registered Nurse or Allied Health Professional working in this trust. A letter has been sent to all nurses and AHPs who attended these programs, inviting them to take part in the study.

Do I have to take part?

It is up to you to decide to join the study. If you think you may be interested in participating the researcher will go through this information sheet with you and answer any questions you may have. If you agree to take part we will ask you to sign a consent form. You are free to withdraw from the study at any time, without giving a reason.

What will I have to do?

If you decide to take part the researcher will arrange an interview with you. This will be at a time and place of your choosing. The interview will last between 30 minutes and 1 hour and will be tape recorded. The researcher will ask questions relating to leadership and how you think leadership is enacted in your

7/12/10

Version 3.1

clinical area. One year after the interview you will be approached again and invited for a follow-up interview. Again, you do not have to take part if you do not wish too.

Is it confidential?

All of your responses in the interview are confidential. No identifying data will be published with the results of the study and only the researcher will have access to the taped interviews. Any data collected about you (for example your name or area of work) will be kept in a locked draw and destroyed soon after the study ends. The anonymous records of the interviews will be used as part of a doctoral thesis.

What are the possible disadvantages or risks of taking part?

As this study is only using interviews to investigate leadership there are no real risks to you taking part. However, if you are concerned about any aspect of the study you can contact the researcher or the Chief Investigator using the details at the end of this information sheet.

What are the possible benefits of taking part?

There will be no direct benefits to you as an individual. However, it is hoped the findings from this study will increase our understanding about leadership within the NHS and within the nursing and AHP professions. The findings may therefore be beneficial to the Trust in which you work, the your profession, and the development of leaders across the whole of the NHS.

What will happen if I don't want to carry on with the study?

You are free to leave the study at any time without giving an explanation. Any interview data that has already been collected may still be used in the study, but no information will be used that would allow an individual to be identified.

What will happen to the results?

This study is being conducted as part of a PhD thesis and will therefore be available to view at the University of Warwick. It is also hoped the findings of this study will be used to develop leadership theory

7/12/10

Version 3.1

and will be published in some academic journals. An internal report will be provided to the Chief Executive of your NHS trust who will be able to circulate the findings among you.

Who is organising and funding the research?

The research is being organised by the University of Warwick and funded by the Economic and Social Research Council. It is being undertaken as part of a doctoral thesis.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Nottinghamshire Research Ethics Committee.

What if I want to make a complaint?

If you wish to ask any questions please contact the researcher whose details are listed first in the contacts section. If you remain concerned about this study or are unsatisfied with the information you have received from the researcher, you can contact the Chief Investigator whose contact details are also listed below. If you are remain unhappy and wish to make a formal complaint you can do so by contacting NHS complaints. Details can be obtained from your Trust.

Contact Details
Researcher
Charlotte Ogilvie

PhD Student

Warwick Business School
The University of Warwick
Coventry

CV4 7AL

Email: lixco5@nottingham.ac.uk

7/12/10

Version 3.1

Chief Investigator

Professor Andy Lockett

Room D1.25 (Social Studies Building)
Warwick Business School
The University of Warwick
Coventry
CV4 7AL

Email: andy.lockett@wbs.ac.uk

Thank you for considering to take part in this study

7/12/10

Version 3.1

Consent Form

(Version 3 – 23/12/09)

Title of Study: Leadership development in the NHS

REC ref: 10/H0408/8

Name of Chief Investigator: Professor Andy Lockett

Name of Participant:

Please initial box

1.   I confirm that I have read and understand the information sheet version number …………dated..................................... for the above study and have had the opportunity to ask questions.

2.   I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.

3.   I understand that relevant sections of my medical notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to

7/12/10

v

Version 3.1

have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

4.   I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports.

5.   I agree to take part in the above study.

_____   _____   _____

Name of Participant   Date   Signature

_____   _____   _____

Name of Principal Investigator   Date   Signature

Study Protocol

Leadership Development in the NHS – An examination of leadership development programs and implementation in an NHS trust

Version 3.1

7/12/10

Short title: Leadership Development in the NHS

REC reference: 10/H0408/8

Trial Sponsor: University of Warwick

Funding Source: ESRC CASE studentship

STUDY PERSONNEL AND CONTACT DETAILS

Sponsor: Jane Prewett

                               Head of Grants and Contracts

                               University House

                               University of Warwick

                               Coventry

                               CV4 8UW

        Tel: 024 7652 3716

Chief investigator: Professor Andy Lockett

                         Room D1.25 (Social Studies Building)

                         Warwick Business School

The University of Warwick

Coventry

CV4 7AL

+44 (0)24 7615 1369

Email: andy.lockett@wbs.ac.uk

Co-investigators: Charlotte Ogilvie

Phone: 07967076726

Email: lixco5@nottingham.ac.uk

Study Coordinating Centre: Nottinghamshire Healthcare Trust

Duncan Macmillan House

Porchester Road

Mapperly

Nottingham

NG3 6AA

SYNOPSIS

Title	Leadership in the NHS – An examination of leadership development programs and implementation in an NHS trust
Short title	Leadership Development in the NHS
Chief Investigator	Professor Andy Lockett
Objectives	To determine how distributed leadership is enacted in the NHS What are the organisational, professional and political contexts which may influence effective nursing leadership? How can these barriers be addressed to enable effective nursing leadership? What do these findings add to a theory of distributed leadership?
Study Configuration	Single Centre
Setting	Mental Health Trust (community and clinical settings)
Number of participants	Approximately 60
Eligibility criteria	Registered nurse working in Nottinghamshire Health Care Trust who has recently attended one of the leadership development programs under examination
Description of interventions	Non-participant observation of leadership development programs Participants will be invited to be interviewed soon after the leadership development program concludes, they will then be invited to a follow up interview one year later. Interviews should last 30-60 minutes.
Duration of study	Overall study should be completed over 18 months (February 2010-September 2011). Each participant will only be invited to attend 2 interviews in this time.
Outcome measures	Interview data will be recorded and then analysed using standard qualitative methods for coding and determining themes.

ABBREVIATIONS

AE   Adverse Event

CI   Chief Investigator overall

CRF   Case Report Form

DAP   Data Analysis Plan

GCP   Good Clinical Practice

ICF   Informed Consent Form

NHS   National Health Service

PI   Principal Investigator at a local centre

PIS   Participant Information Sheet

REC   Research Ethics Committee

R&D   Research and Development department

STUDY BACKGROUND INFORMATION AND RATIONALE

Leadership as a concept is enigmatic with a multitude of dimensions and definitions (Burns 1978; Hunt 1999). It is an ever more popular research area, exacerbated by the demands of an increasingly connected and complex economy requiring organisations to adapt and change to survive (Regine and Lewin 2000; Ford and Harding 2007). The increase of leadership development programs across the public and private sector indicates the level of importance placed on good leadership skills in relation to organisational performance (Van Wart 2003; Ford and Harding 2007). However, the lack of a universal definition and the diverse range of leadership theories, none of which appear to fully encompass the process of leadership in complex organisations, have clouded the issue (Dess and Picken 2000; Avery 2004). An increasingly popular suggestion, and the definition for the purposes of this study, implies that leadership is a social dynamic process which cannot be isolated and observed and which will alter according to time, social context and personal perceptions (Osborn, Hunt et al. 2002; Avery 2004; Kort 2008).

The National Health Service (NHS) is a particularly complex and unique organisation. A recent report from the Department of Health (Darzi 2008) highlighted the importance of leadership within the health service, particularly from clinicians at the front line of patient services. The report indicates a need for distributed leadership throughout all levels of the NHS, and the need for more leadership development programs. However, the theory of distributed leadership is relatively new, and the few empirical studies which have been conducted in the public sector have been mainly concerned with leadership in education (Currie, Lockett et al. 2009a; Currie, Lockett et al. 2009b). Research into the ability to enact distributed leadership in the NHS is scarce.

Leadership development programs within the NHS have previously been aimed primarily at doctors and managers who were seen as hierarchically higher than other professionals. Effective nursing leadership can improve the quality of patient care but the ways in which nurses lead, and the organisational barriers they face, is an under researched area. Clinical leadership has not been supported within the organisation and the outcomes of and barriers to leadership have not been evaluated. The NHS is a particularly complex institution which produces challenges for leaders attempting to deliver system-wide change.

This study sets out to investigate the theories underpinning leadership development programs in Nottinghamshire Healthcare Trust, with a particular focus on registered nurses. The trust has recently developed a number of leadership programs which focus on distributing leadership throughout the organisation. The programs are open to all staff, from electricians and cleaners to psychiatrists and lead nurses, making the leadership programs particularly unique.

The effectiveness of and barriers to distributed clinical leadership will be investigated, as will the specific challenges faced by nurses as a profession. It is hoped that the findings of this study will provide a greater understanding and development of the theory of distributed leadership, as well as an insight into the organisational and professional barriers to clinical leadership, allowing recommendations to be made for leadership policies at a local and national level.

STUDY OBJECTIVES AND PURPOSE

PURPOSE

The purpose of the study is to enhance the current understanding and theory of distributed leadership with a particular focus on the barriers which may occur when nurses in the NHS attempt to enact it. It is hoped this will allow the theoretical model of distributed leadership to be developed and for recommendations to be made to enhance distributed clinical leadership in the NHS, ultimately providing better patient care.

PRIMARY OBJECTIVE

To interview Registered Nurses who have taken part in a leadership development program and determine how they perceive leadership, how they hope to enact it, and by conducting longitudinal interviews, determine if there are any organisational, professional or political elements which may enhance or inhibit their ability to lead.

SECONDARY OBJECTIVES

To use the findings from the interviews, combined with observations of the leadership development programs and supporting Trust documentation, to further explore distributed leadership and examine the effects it has on clinical practice and patient outcomes.

STUDY DESIGN

STUDY CONFIGURATION

This will be a single centre study, with purposeful rather than statistical sampling of all registered nurses who recently took part in a leadership development program within the trust. The researcher will attend a number of the program meetings to observe what is being taught. Participants will then be invited via trust email to take part in two longitudinal interviews, one soon after the program finishes and one a year later.

The interviews will be conducted at a time and place which is convenient to the participant. It is anticipated that this will either be in a public area of the NHS Trust grounds, at the University of Warwick, or at the participant's home.

The interviews will be tape recorded and subsequently transcribed and coded. The interviews will be semi-structured and guided by participant responses. The primary objective of the interviews is to determine how the participants perceive leadership and how they hope to enact it. By conducting an interview one year later these comments can be compared and their success or inability in enacting leadership analysed within the organisational, professional and political context.

STUDY MANAGEMENT

The study will be managed by the PhD student, Charlotte Ogilvie, under supervision from the Chief Investigator and another academic supervisor.

Charlotte Ogilvie will gather informed consent from all participants and conduct the interviews. The interviews will be tape recorded and stored as anonymous source data. Any corresponding identifying information will be stored separately and used only for researcher identification and correlation between longitudinal interviews, this data will not be used in the research findings. The data will be stored in the University of Warwick in a locked desk. All identifying data will be destroyed soon after the study ends. The anonymous source data will be stored in a locked desk for some years after the study ends. The Chief Investigator will be the custodian of this data.

DURATION OF THE STUDY AND PARTICIPANT INVOLVEMENT

Each participant is already enrolled in a leadership development program. The researcher will begin by observing the programs to gather some idea of the context in which participants are basing their ideas of leadership. Participants will be invited to participate in an interview soon after the end of the program. The interviews should last between 30-60 minutes. They will then be invited to be

interviewed again one year later. This interview should also last 30-60 minutes. This will be the last intervention with the participant.

It is hoped that all interviews will have been conducted and all observations completed within an 18 month time period, from enrolment of participants to the cessation of any data collection.

End of the Study

The end of the study will be the last interview with the participants.

SELECTION AND WITHDRAWAL OF PARTICIPANTS

Recruitment

Participants will be recruited from Nottinghamshire Healthcare Trust. The initial approach will be via an email, written by the researcher inviting the participant to be interviewed, and sent out via a Trust administrator to participant Trust email accounts. If no response is received a second email will be sent out after one month.

A participant information sheet will be sent out with the email. Participants will then have the opportunity to meet with the researcher to ask any questions and discuss the study. At this point if they still wish to continue, informed consent will be documented and an interview will be conducted. The participant will decide where to conduct the interview, it is anticipated that this will occur either at the NHS Trust grounds, the University of Warwick, or at the participant's home.

The information sheets and consent form will not be provided in any language other than English as it is assumed due to the nature of their jobs the participants will have a solid grasp of English.

It will be explained to the potential participant that that entry into the study is entirely voluntary. It will also be explained that they can withdraw at any time but attempts will be made to avoid this occurrence. In the event of their withdrawal it will be explained that their data collected so far cannot be erased and we will seek consent to use the data in the final analyses where appropriate.

Inclusion criteria

Any Registered Nurse working within Nottinghamshire Healthcare Trust who has recently attended a leadership development course

Exclusion criteria

Anyone under 18

Anyone not fulfilling the inclusion criteria

Expected duration of participant participation

Study participants will be participating in the study for 12-18 months. They will only be approached twice in this time.

Participant Withdrawal

Participants may be withdrawn from the study either at their own request or at the discretion of the Investigator. They will be made aware they can withdraw at any time and without giving a reason. Participants will be made aware (via the information sheet and consent form) that should they withdraw the data collected to date cannot be erased and may still be used in the final analysis.

Informed consent

All participants will provide written informed consent. The Consent Form will be signed and dated by the participant before they enter the study. The Investigator will explain the details of the study and provide a Participant Information Sheet, ensuring that the participant has sufficient time to consider participating or not. The Investigator will answer any questions that the participant has concerning study participation.

Informed consent will be collected from each participant before they undergo any interventions related to the study. One copy of this will be kept by the participant and one will be kept by the Investigator.

Should there be any subsequent amendment to the final protocol, which might affect a participant's participation in the study, continuing consent will be obtained using an amended Consent Form which will be signed by the participant.

STUDY REGIMEN

Each participant will receive an email inviting them to participate in an interview. The interview will last 30-60 minutes. They will be invited to attend another interview one year later. These are the only interventions that will occur with each participant.

Permission has been given from the Chief Executive of the trust for the investigator to have access to evaluation forms gathered from the leadership development programs, as well as some informal trust evaluation forms regarding improved outcomes on wards following leadership programs. These will be used as secondary sources of information and will not require any participants to be involved.

.

Criteria for terminating the study

It seems unlikely that the study will be terminated. Issues such as a major change in the infrastructure of the trust, or unforeseen circumstances which may raise safety concerns cannot be predicted but may force the investigation to close. Again, this seems unlikely.

STATISTICS

Methods

Due to the qualitative nature of the methods, the data analysis will take on an appropriate form. Interviews will be tape recorded and transcribed. They will then be coded and analysed by the investigator in an attempt to distinguish themes relevant to the research questions. The findings will be supported with secondary data such as observations from the development programs and informal trust evaluation sheets collected after program sessions or ward outcomes. These evaluation forms will not be statistically examined, they were not produced by the researcher and will be used only to contextualise and support interview data, not to make generalisable assumptions.

Sample size

The sampling methods used are purposeful as a specific social group undergoing a specific intervention is being investigated. All potential participants in this group will be approached. It is impossible to say how many will agree to take part at this point.

ADVERSE EVENTS

The occurrence of adverse as a result of participation within this study is not expected and no adverse event data will be collected.

ETHICAL AND REGULATORY ASPECTS

There seem to be two main ethical and design issues which need to be addressed: firstly, when interviewing clinicians it is important not to detract from patient care; and secondly, whether responses to the interviews will provide accurate and frank information, or whether nurses will produce answers which they believe to be 'correct'.

The biggest ethical concern in this study is to ensure that interviewing clinicians does not detract from patient care. The development programs being observed do not take place within a clinical environment and all nurses involved in the programs have been awarded study time away from the ward to attend these days. However, the interviews will take place after the programs have finished and the nurses are back on the wards. It will therefore be important to ensure that any participants in the study are interviewed in their own time, not during the course of their shift, and that the interviews occur in a nonclinical area to ensure no facilities or space is being taken up by the researcher.

It is clearly important to the validity of the study that the answers elicited are honest and accurate perceptions of what the participants believe to be true. This will allow the success or inhibition of leadership practices in different contexts to be analysed. If respondents answer in a way that portrays themselves in a positive light but does not describe the barriers they faced in enacting leadership, our understanding of the phenomena may become skewed and inaccurate. Being aware of this issue will hopefully allow the researcher to address it early on by emphasising to the participants that the responses provided will be totally confidential and no identifiable information will be used.

It is unlikely that any personal or sensitive information will be disclosed during the interviews. Any information which allows identification of individuals will be removed from the interview transcripts before data publication. The potential of a clinician admitting to misconduct which has harmed a patient is remote due to the nature of the subject being discussed. However, should this occur the researcher will be ethically responsible to report this discussion to the appropriate manager within the Trust, or to a professional governing body (The NMC) should the disclosure be serious enough to warrant this.

ETHICS COMMITTEE AND REGULATORY APPROVALS

The study will not be initiated before the protocol, consent forms and participant information sheets have received approval / favourable opinion from the Research Ethics Committee (REC), and the respective National Health Service (NHS) Research & Development (R&D) department. Should a protocol amendment be made that requires REC approval, the changes in the protocol will not be instituted until the amendment and revised informed consent forms and participant information sheets have been reviewed and received approval / favourable opinion from the REC and R&D departments. A protocol amendment intended to eliminate an apparent immediate hazard to participants may be implemented immediately providing that the REC are notified as soon as possible and an approval is requested. Minor protocol amendments only for logistical or administrative changes may be implemented immediately; and the REC will be informed.

The study will be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social care, 2005.

INFORMED CONSENT AND PARTICIPANT INFORMATION

The process for obtaining participant informed consent or assent and parent / guardian informed consent will be in accordance with the REC guidance, and Good Clinical Practice (GCP) and any other regulatory requirements that might be introduced. The investigator or their nominee and the participant shall both sign and date the Consent Form before the person can participate in the study.

The participant will receive a copy of the signed and dated forms and the original will be retained in the Study records.

The decision regarding participation in the study is entirely voluntary. The investigator or their nominee shall emphasize to them that consent regarding study participation may be withdrawn at any time without penalty. No study-specific interventions will be done before informed consent has been obtained.

The investigator will inform the participant of any relevant information that becomes available during the course of the study, and will discuss with them, whether they wish to continue with the study. If applicable they will be asked to sign revised consent forms.

If the Consent Form is amended during the study, the investigator shall follow all applicable regulatory requirements pertaining to approval of the amended Consent Form by the REC and use of the amended form (including for ongoing participants).

RECORDS

Case Report Forms

Each participant will be assigned a study identity code number, for use on CRFs, other study documents and the electronic database. The documents and database will also use their initials (of first and last names separated by a hyphen or a middle name initial when available) and date of interview.

CRFs will be treated as confidential documents and held securely in accordance with regulations. The investigator will make a separate confidential record of the participant's name and Participant Study Number, to permit identification of all participants enrolled in the study, in case additional follow-up is required. CRFs shall be restricted to Andy Lockett, Charlotte Ogilvie and Graeme Currie and recorded as such in the study records.

All paper forms shall be filled in using black ballpoint pen. Errors shall be lined out but not obliterated by using correction fluid and the correction inserted, initialled and dated.

The Chief or local Investigator shall sign a declaration ensuring accuracy of data recorded in the CRF.

The chief investigator will act as custodian for the data collected. All electronic data will be stored on a password protected computer in a password protected file.

Source documents

Source documents shall be filed at the investigator's site and may include but are not limited to, consent forms, study records, field notes, interview transcriptions and audio records. A CRF may also completely serve as its own source data. Only study staff shall have access to study documentation other than the regulatory requirements listed below. These sources will be stored in a locked desk in a locked office.

Direct access to source data / documents

The CRF and all source documents shall made be available at all times for review by the Chief Investigator, Sponsor's designee and inspection by relevant regulatory authorities.

DATA PROTECTION

All study staff and investigators will endeavour to protect the rights of the study's participants to privacy and informed consent, and will adhere to the Data Protection Act, 1998. The CRF will only collect the minimum required information for the purposes of the trial. CRFs will be held securely, in a locked room, or locked cupboard or cabinet. Access to the information will be limited to the trial staff and investigators and any relevant regulatory authorities (see above). Computer held data including the study database will be held securely and password protected. All data will be stored on a secure dedicated web server. Access will be restricted by user identifiers and passwords (encrypted using a one way encryption method).

Electronic data will be backed up every 24 hours to both local and remote media in encrypted format.

QUALITY ASSURANCE & AUDIT

INSURANCE AND INDEMNITY

Insurance and indemnity for clinical study participants and study staff is covered within the NHS Indemnity Arrangements for clinical negligence claims in the NHS, issued under cover of HSG (96)48. There are no special compensation arrangements, but study participants may have recourse through the NHS complaints procedures.

The University of Warwick has taken out an insurance policy to provide indemnity in the event of a successful litigious claim for proven non-negligent harm.

STUDY CONDUCT

Study conduct will be subject to systems audit for inclusion of essential documents; permissions to conduct the study; CVs of study staff and training received; local document control procedures; consent procedures and recruitment logs; adherence to procedures defined in the protocol (e.g. inclusion / exclusion criteria, timeliness of visits); accountability of study materials and equipment calibration logs.

The Study Coordinator, or where required, a nominated designee of the Sponsor, shall carry out a site systems audit at least yearly and an audit report shall be made.

STUDY DATA

Monitoring of study data shall include confirmation of informed consent; source data verification; data storage and data transfer procedures; local quality control checks and procedures, back-up and disaster recovery of any local databases and validation of data manipulation. The Study Coordinator,

or where required, a nominated designee of the Sponsor, shall carry out monitoring of study data as an ongoing activity.

Entries on CRFs will be verified by inspection against the source data. A sample of CRFs (10%) will be checked on a regular basis for verification of all entries made. In addition the subsequent capture of the data on the study database will be checked. Where corrections are required these will carry a full audit trail and justification.

Study data and evidence of monitoring and systems audits will be made available for inspection by the REC as required.

RECORD RETENTION AND ARCHIVING

In compliance with the ICH/GCP guidelines, regulations and in accordance with the University of Warwick Research Code Of Conduct, the Chief or local Principal Investigator will maintain all records and documents regarding the conduct of the study. These will be retained for at least 7 years or for longer if required. If the responsible investigator is no longer able to maintain the study records, a second person will be nominated to take over this responsibility.

The study documents held by the Chief Investigator on behalf of the Sponsor shall be finally archived at secure archive facilities at the University of Warwick. This archive shall include all study databases and associated meta-data encryption codes.

DISCONTINUATION OF THE TRIAL BY THE SPONSOR

The Sponsor reserves the right to discontinue this study at any time for failure to meet expected enrolment goals, for safety or any other administrative reasons. The Sponsor shall take advice as appropriate in making this decision.

STATEMENT OF CONFIDENTIALITY

Individual participant medical or personal information obtained as a result of this study are considered confidential and disclosure to third parties is prohibited with the exceptions noted above.

Participant confidentiality will be further ensured by utilising identification code numbers to correspond to treatment data in the computer files.

Data generated as a result of this study will be available for inspection on request by the University of Warwick representatives, the REC, local R&D Departments and the regulatory authorities.

PUBLICATION AND DISSEMINATION POLICY

This study is being conducted as part of a doctoral thesis which will be published and kept in the University of Warwick library. It is aimed that this will be submitted in late 2012.

It is hoped that this thesis will form the basis of a number of papers which will be published in peer reviewed journals and disseminated via conference and other university presentations. These papers and presentations will be published concurrently with data collection and finding analysis.

All data used in these publications will be anonymous. No identifiable data will be used.

An internal report will be provided to the Chief Executive of the NHS Trust outlining the findings and making recommendations relating to the leadership development programs and the development of their clinical nurse leaders.

USER AND PUBLIC INVOLVEMENT

The learning and development team and the Chief Executive of the NHS Trust have been involved in the identification of a research question and the design of the study. They will also be helping to disseminate the results using the internal report which will be provided for them.

STUDY FINANCES

Funding source

This study is funded by an ESRC CASE studentship

Participant stipends and payments

Participants will not be paid to participate in the study.