



Identifying paradox: A grounded theory of leadership in overcoming resistance to change

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Abstract

The full grounded theory method was used in the present study to investigate nursing leadership in a New Zealand hospital setting. One finding that emerged clearly from the research was the important role played by organizational politics in both facilitating the process of leadership and in confounding it. Data were collected over a two-year period. The range of data sources included nonparticipant observation, informal/unstructured and formal/semistructured interviews, document analysis, and the Multifactor Leadership Questionnaire (MLQ). Data triangulation within the grounded theory method is a major contribution of this study. Nurse leaders displayed high levels of transformational leadership according to the questionnaire data. However, qualitative analysis of the data suggested that other factors were working to prevent nurse leaders from maximizing organizational change outcomes. Two near-core categories partially explained why transformational nurse leaders were not realizing their leadership potential. One near-core category was the process of *repressing leadership*, the other was *multiple realities*. The highest level of abstraction of the data led to the emergence of the substantive basic social process of *identifying paradox*. Identifying paradox was conceptually very close to the definition of politics in organizational leadership which is the “constructive management of shared meaning.” This core category explained the social process by which the staff either legitimize or reconcile paradoxical understandings created from the *multiple realities* of the three subcultures working in the hospital setting. If paradoxes are identified and reconciled, and *multiple realities* converge, organizational change efforts are more likely to be accepted by the staff because the change is in line with their reality. Conversely, if paradoxes are not identified and/or legitimized, *multiple realities* diverge and organizational change efforts are less likely to be accepted by the staff. Findings are interpreted from the political perspective.

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1. Characteristics of the leadership phenomenon

This research was prompted by a need to investigate leadership processes within the substantive context of the conduct of nursing in a hospital environment. Some characteristics of the phenomenon of leadership are now discussed, which conclude that the full grounded theory method is the most suitable method with which to conduct such research. Recent concerns of leadership researchers have involved incorporating the notion that leadership is a dynamic, situation-based social process that is contingent upon culture and context. Several researchers have described four more specific concerns with the nature of leadership. First, leadership is connected with the notion of change (Osborn, Hunt & Jauch, 2002; Parry, 1998). Second, leadership involves influencing others (Bess & Goldman, 2001; Zaccaro, Rittman, & Marks, 2001). Third, leadership occurs within a group context as well as within a dyadic relationship (Ammeter, Douglas, Gardner, Hochwater, & Ferris, 2002; Hackman & Johnson, 1996; Zaccaro et al., 2001). Finally, leadership involves goal attainment (Ohman, 2000). Each characteristic is now examined in more detail.

First, an overarching integrative theme of leadership literature is the concept of change. Through times of major change, effective leadership has been attributed to successful outcomes (Hackman & Johnson, 1996; Yukl, 2002). The concept of change within the leadership literature adds a temporal dimension to leadership and supports the notion that leadership can be regarded as a process. Therefore, change incidents may form the basis for investigating the leadership process.

Defining leadership as a process supports the notion that leadership is more than a linear, mono-directional event. Leadership is interactive between the leader and the follower and extends beyond the formally designated leader to include anyone taking on a leadership role (Neubert, 1999). Similarly, Hackman & Johnson's (1996) conceptualization of leadership from the communication perspective notes the cyclical nature of communication and leadership.

Second, the ability to influence others is another defining feature of leadership. However, Guest (1987) observed that the traditional approach to leadership has repeatedly failed to consider the reciprocal influence process. The reciprocal influence process means that leaders influence followers and followers influence leaders. Similarly, it could be posited that managers exert leadership influence over subordinates and subordinates exert leadership influence over managers. It has been argued that leadership can be considered a social influence process (Bess & Goldman, 2001; Hunt, 1991; Parry, 1998; Yukl, 2002). Kent, Johnson, and Graber (1996) noted that leaders exert influence over situations and they engage and interact with others.

The third issue is that leadership occurs within a group context. Without individuals or groups to influence, leadership cannot occur. For leadership to occur, there also must be followership. For the purposes of the present study at least, the group context has been the assumption that was made. The fourth characteristic is that of goal attainment. Within the group the leader influences, another characteristic of leadership is the setting of direction or the attainment of goals. Therefore, leadership involves directing a group towards some end point or accomplishing some task. This includes defining and articulating a direction according to external and environmental contingencies for their followers (Zaccaro & Banks, 2001). Similarly, transformational leadership theory includes the idea of inspirational motivation as one way of encouraging followers to envision attractive future states (Bass, 1998).

Therefore, this research was prompted by a need to conduct research in order to develop a theory of leadership explaining the process by which managers lead their associates through organizational changes to attain positive outcomes for their organization and for their clients. We did not test a political

theory of leadership. Rather, organizational politics emerged clearly as a major component of the leadership process that was uncovered. In accordance with the advice of [Conger \(1998\)](#), [Hunt and Ropo \(1995\)](#), [Parry \(1998\)](#), and others, it was determined that the full grounded theory method would provide valid and reliable, albeit substantive findings which could explain these phenomena within a suitable organizational environment. The triangulation of qualitative and quantitative data within the full grounded theory method was found to be a major innovation of this work.

2. Organizational environment

The organization under investigation was a public hospital in the North Island of New Zealand. For the purposes of the present article, the hospital will be known as City Hospital. City Hospital serves a base population of 255,000 within a major city. Further specialist tertiary care facilities serve a population base of 900,000 in the wider region ([Capital Coast Health Website, 2001](#)). The aim of this study was to develop a theory of leadership explaining the process by which nurse leaders lead nurses through organizational changes to attain positive outcomes for nursing and for their clients. Within the context of this research, leaders are not necessarily individuals. The leader could be ‘nurses,’ in particular “nurse managers.” The target ([Ammeter et al., 2002](#)) could be “other nurses” or “other managers.” There is no implicit assumption of individual or dyadic leader–follower relationships, as with much of the political leadership literature. It is “leadership” that was studied, not “leaders.”

City Hospital is fairly typical of healthcare organizations in its change efforts. However, the restructuring of bureaucracies, the introduction of new technologies, and the changing demands of the community it serves had led to a degree of uncertainty and discomfort among the staff. In the 2000–2005 Strategic Plan, it was noted that constant financial pressure has dominated the City Hospital Board’s agenda. The response to this pressure had resulted in the hurried and incomplete implementation of change strategies. While the need for change remains, the staff were “bruised from the changes in the past” ([Capital and Coast Health Board, 2000, p. 8](#)).

Not surprisingly, negative consequences from continuous, rapid change have also been typical of other healthcare environments undergoing similar change. Recent overseas studies of healthcare professionals have cited anxiety ([Crow, 2001](#)), resistance to change ([Simpson, 2001](#)), burnout ([Fackelmann, 2001](#); [Parish, 2001](#)), sickness ([Kivimaki, Vahtera, Pentti, & Ferrie, 2000](#)), and apathy ([Kivimaki et al., 2000](#); [Marshall, 1999](#)) as the results of continuous change to healthcare systems. In any industry, such environments are ripe for the manifestation of the “dark” side of organizational politics ([Ferris, Adams, Kolodinsky, Hochwater, & Ammeter, 2002](#)). The potential for competition for scarce resources has the possibility of releasing self-serving behaviors. Therefore, the need for political leadership is all the greater.

Thus, nurses at City Hospital have been affected by the organizational changes, but also they have had to cope with changes occurring within their profession. Issues including increased ownership, empowerment, and a more seamless structure in healthcare have been the foci of nurse leaders within the organization and across the country.

Changes within nursing and in the larger organizational environment have appeared to reflect a move from medical models of curative healthcare to nursing models of prevention and well-being. In line with nursing’s drive toward a seamless organization, City Hospital’s Strategic Plan (2000) also proposed

changes to improve communication between the staff, patients, and communities. In turn, this was expected to lead to the greater promotion of wellness and illness prevention. Changes to the way City Hospital had addressed healthcare issues were reflective of the traditional, holistic nursing philosophies, including illness prevention and working with the community.

Nursing leadership, within an environment of continuous change, has been considered vital if the role and scope of nursing is to meet changes in society and technology (Ministerial Taskforce on Nursing, 1998; Ministry of Health, 1998). Furthermore, the importance of leadership through the change has been identified repeatedly throughout the nursing and leadership literatures. If nurse leaders are to lead nursing to greater levels of effectiveness and improved collaborative practice, research into leadership phenomena will provide one means to enable this progress to occur. Consequently, this research is driven by a desire to understand how leadership processes operate in such an environment.

3. Research objectives

Four research objectives drove this research. The first objective was to bring quantitative psychometric data into grounded theory analysis. This is an innovation which hitherto has been lacking in grounded theory research. The second was to better understand the leadership processes operating within the nursing environment of a hospital undergoing organizational change. The third objective was to determine the basic social process reflecting those leadership processes. The fourth objective was to generate a theory explaining the phenomenon of nursing leadership within this environment.

4. Method—the grounded theory approach

Grounded theory is a method well suited to enhancing our knowledge of leadership. Grounded theory uses qualitative research methods with the aim of generating theory which is grounded in the data, rather than testing existing theories (Glaser, 1978, 1992; Strauss & Corbin, 1990). The importance of the grounded theory approach in the present study was that it incorporated the complexities of the organization under investigation without discarding, ignoring, or assuming away relevant variables. Therefore, the richness of the data ensured that the resulting theory was able to provide a holistic understanding to the leadership process for participants and fellow researchers alike.

4.1. Data

The concurrent data collection and analysis involved in this grounded theory study included approximately 50 hours of nonparticipant observation over three wards, 30 hours of semistructured interviews, 25 informal and unstructured interviews, document analysis, and the distribution of the Multifactor Leadership Questionnaire (MLQ). The formal semistructured interviews were carried out with six team leaders (nurses in charge of wards), eight nurses (from three different wards), two doctors, two nurse coordinators reporting to team leaders, and three senior nurse managers. The semistructured interviews followed the protocol set down by Parry (1999; see Appendix A), and lasted for between one

and two hours. One interviewee was formally interviewed twice, so there was a total of 22 semi-structured interviews. These interviews were taped and transcribed, then entered into NVivo software to assist with analysis.

Unstructured interview respondents included team leaders, nurses, and support staff, such as social workers and orderlies. These informal interviews were conducted during the process of nonparticipant observation, and each lasted for approximately 30 minutes. The content of these unstructured interviews consisted of interpretation of incidents that were occurring at the time, and were based around the observations and points of concern occurring to the principal researcher in situ. Handwritten memos were taken during these interviews and entered into NVivo software to assist with analysis. During the 50 hours of nonparticipant observation, handwritten and taped memos were made by the principal researcher and entered into NVivo software to assist with analysis.

Data collection was conducted over a two-year period. Throughout this time, several change incidents were investigated through the use of *theoretical sampling*, a technique in which the selection of respondents is guided by the themes/categories emerging from the data. Theoretical sampling was conducted concurrently with data analysis. This meant that the researcher would theorize and write up ideas about the categories as they emerged (Glaser, 1978). Theoretical categories emerged from the conceptualization of substantive categories and their relationships to each other as hypotheses to be integrated into a theory (Glaser, 1978).

4.1.1. Quantitative data

An additional data source, a quantitative questionnaire, was considered essential to the present research. The MLQ (5 ×) (Revised) contains 45 items identifying and measuring leadership behaviors. Nine leadership factors represent the full range of leadership styles. The five transformational leadership behaviors are idealized attributes, idealized behaviors, inspirational motivation, intellectual stimulation, and individualized consideration. The three transactional leadership behaviors are contingent reward, management-by-exception (passive), and management-by-exception (active). Nonleadership is measured by laissez-faire behavior. Each of the nine factors is measured by four highly intercorrelated items (Bass & Avolio, 1997). The MLQ is constructed on a previously developed theory of transformational leadership (Bass & Avolio, 1997).

The reason for using a quantitative instrument alongside the qualitative data was to provide an in-depth understanding of the phenomenon from multiple perspectives. This data triangulation has been described by some researchers as multiple methods used to collect the same information (Denzin, 1970). Similarly, Bryman (1988) noted that triangulation can enhance the quality of information if the multiple methods can provide mutual confirmation. However, until now, quantitative data have been seldom used in grounded theory research. The use of the MLQ to complement the use of interview and observation data was seen as an effective way to achieve the triangulation of data. Conger and Toegel (2002) and Kan (2002) support the use of data triangulation in organizational research such as this.

One hundred and ninety-six respondents rated the leadership of their 20 nurse managers with the MLQ. Up to 12 questionnaires were sent to the people who worked closely with each of the 20 nurse managers. In many cases, this represented the entire work group of the nurse manager. Almost all respondents were fellow nurses or associated professionals. Two hundred and thirty questionnaires were distributed and 196 were returned. This represents a response rate of 85%. The high response rate was achieved partly because the questionnaires were hand delivered by the principal researcher, and collected

either in person or by reply-paid envelopes. The principal researcher sent out several reminders by mass email distribution and in person to the staff of the wards. Twenty-five respondents (12%) were at a ‘higher’ level than the nurse manager being rated; 58 (30%) were at the ‘same’ level; 63 (32%) were at a “lower” level, and 50 (26%) were at an “other” level. The results of the MLQ were analyzed both quantitatively and qualitatively.

4.2. Analysis

Analysis of qualitative and quantitative data was conducted concurrently, and in several iterations. Open coding determined the categories that were represented in abstract by the data. To determine the relationships between categories, a number of coding “families” (Glaser, 1978) were employed. The first coding family is the “Six Cs” in which the researcher considers the causes, consequences, contexts, contingencies, covariances, and conditions for each data category. Theoretical coding using the Six Cs allows the researcher to ask a number of questions of the data and categories to help clarify their relationship with one another. Those questions are as follows:

- Is it a cause or a consequence of some other category?
- What are the intervening conditions between the causes and consequences?
- Within what context does this category emerge? Context refers to the location of events or incidents pertaining to a phenomenon (Strauss & Corbin, 1990).
- Is this category a contingency (having a bearing on another category)? In other words, what is change in this category dependent upon? This refers usually to unplanned change (Strauss & Corbin, 1990; Swanson, 1986).
- Is there covariance between this category and other categories? Covariance occurs when one category changes with the changes in another category (Strauss & Corbin, 1990).

By asking these questions of the data, and seeking answers, the level of abstraction of the categories increases progressively.

“Causes” reflect questions aimed at considering the reason or explanation for the occurrence of a given phenomenon. “Consequences” are the effects of the phenomenon. In terms of the nomothetic approaches to research, these two Cs reflect the relationship between dependent and independent variables. A contingency is, in effect, a moderating variable. An intervening condition is, in effect, an intervening variable. Covariance between categories is equivalent to correlation. The context accounts for the setting and events imposing on the setting. These equivalencies between the ideographic

Table 1
Translation of grounded theory data analysis concepts

Grounded theory concepts	Equivalent nomothetic concepts
Cause	Independent variable
Consequence	Dependent variable
Contingency	Moderating variable
Condition	Intervening variable
Covariance	Correlation
Context	Context

grounded theory approach to data analysis and the nomothetic concepts traditionally used in mainstream leadership research are summarized in Table 1.

Glaser (1978, 1992) considered that asking the Six C questions of the data was the first of 18 general coding schemas, or families, to consider when coding data. The remaining 17 coding families are the following:

1. process
2. degree (including extent, limit, range, and intensity)
3. dimensions
4. types
5. strategies
6. interactions (including reciprocity and interdependence)
7. self-identity
8. cutting point (including boundaries, junctures, and dichotomies)
9. means–end
10. cultural families (social categories)
11. consensus families (clusters, conformity, and mutuality)
12. mainline families (including social controls, recruitment, and socialization)
13. theoretical families
14. ordering or elaboration families (including structural and temporal)
15. unit families (various collectives)
16. reading families
17. models

In the present research, all 18 coding families, as described by Glaser (1978), were used at various stages of analysis. They assisted with the conceptualization of categories and the relationships between them. The consideration of a range of theoretical coding techniques enabled the researcher in the present study to remain sensitive to render explicitly the subtleties of relationships in the data. It is also important to note that the coding techniques are flexible and may overlap considerably with each other.

Categories were compared and abstracted further through the use of memo writing and *open* and *theoretical coding* until all the categories were saturated; that is, no new categories relating to the emerging core category or main theme emerged. The result was a dense, rich theory, which integrated the categories and explained points of variation.

4.2.1. Use of NVivo software

Qualitative data analysis was assisted by the Nonnumerical Unstructured Data: Indexing, Searching and Theorizing (NUD*IST Vivo or NVivo), a computer software package designed by Qualitative Research and Solutions (Fraser, 1999). NVivo was used for the following analytic procedures:

- Storage and categorizing of interview transcripts, memos, and other documents.
- Creation of categories through computer-assisted coding.
- Conducting searches relevant to analysis, in order to generate reports.

- Moving and linking data as higher order themes emerged.
- Basic hierarchical models of codes.

The memos generated in NVivo formed the basis for much of the final write-up in the present study. While NVivo assisted with the storage and categorizing of data, the analysis was conducted in accordance with grounded theory methodology. The results of the grounded theory analysis are now discussed. We stress that although we have gathered quantitative data and conducted exploratory statistical analysis thereon, this is not a quantitative piece of research. The same questions were asked of the questionnaire data as were asked of the observation and interview data. The means, tests of difference, scale reliabilities, and the gratuitous comments provided by respondents were all interrogated to help determine causes, consequences, contingencies, interactions, dimensions, and so on.

5. Findings

5.1. *Conflicting MLQ results*

A very interesting finding emerged during the early and intermediate stages of analysis. This was that the MLQ data provided findings which contrasted starkly with the findings from analysis of the interview and observation data. For example, nurse leaders at City Hospital displayed at least as much transformational leadership as the New Zealand norms. Transformational leadership behaviors are typically considered the most effective form of leadership through times of organizational change (Bass, 1985). If we were to have analyzed only the MLQ data, we would have concluded that nurse leadership was as good as that displayed in industry generally. By contrast, if we were to have used only the qualitative data, we would have concluded that nurse leadership is greatly lacking. Such a contradictory finding necessitated further iterations of analysis and interpretation in accordance with the principles of theoretical coding and theoretical sampling.

Some of that analysis is now detailed. Table 2 summarizes the comparative reliabilities between the New Zealand Leadership Survey and the nurse sample from the present study.

The New Zealand national norms were calculated from a database comprising approximately 600 respondents who rated the leadership of their managers (MLQ Pty, 2001). The data for the present research were gathered according to the same process as the national norms. A one-sample *t* test revealed that nurse leaders display significantly higher levels of leadership than the national norms in all transformational leadership behaviors. The results also revealed significantly more of the transactional behaviors contingent reward, management-by-exception (active), and laissez faire. Management-by-exception (passive) was not significantly different.

Due to the unequal sample sizes and different standard deviations, the SPSS output for unequal variances was used. The Cronbach alpha (α) reliabilities of the factors were generally low. The initial interpretation of this finding was that the MLQ was not an adequate measure of leadership within this substantive context. However, qualitative examination of the items that explained the low reliabilities for each factor provided further insight into how nursing leadership seemed to be repressed within the hospital.

For example, the individualized consideration factor also had a low reliability α of .46 with a relatively high transformational mean score of 3.02. However, qualitative data indicated that high team

Table 2

Means, standard deviations, α reliabilities, and differences in means for MLQ results of New Zealand and nurse sample

Factors	New Zealand norm sample				Nurse sample				Difference in means	<i>t</i> Score (<i>df</i>)
	<i>N</i>	Mean	<i>SD</i>	α	<i>N</i>	Mean	<i>SD</i>	α		
<i>Transformational leadership</i>										
Idealized attributes	604	2.96	.72	.70	196	3.13	.68	.68	.17	4.633 (195)***
Idealized behaviors	598	2.70	.73	.67	192	2.98	.74	.67	.28	5.275 (191)***
Inspirational motivation	602	2.89	.75	.80	195	3.07	.74	.83	.18	5.051 (194)***
Intellectual stimulation	604	2.73	.71	.77	194	2.87	.72	.58	.14	3.284 (193)**
Individualized consideration	600	2.78	.74	.71	194	3.02	.79	.46	.24	5.573 (193)***
<i>Transactional leadership</i>										
Contingent reward	601	2.94	.71	.66	196	3.04	.73	.61	.10	4.700 (195)***
MBE (active)	596	1.88	.95	.76	193	2.23	.96	.71	.35	3.256 (192)**
MBE (passive)	599	1.11	.74	.61	193	1.20	.96	.71	.09	1.382 (192)
Laissez-faire	603	0.66	.64	.65	194	0.85	.94	.80	.19	2.134 (193)*

Scale 0–4.

* $p < .05$.** $p < .01$.*** $p < .001$.

leader workload and the nature of shift work meant that nurse leaders were unable to consistently display the levels of individualized consideration they intended. Nurse respondents noted many team leaders' attempts to be individually considerate, and their inability to consistently demonstrate this kind of leadership successfully. For example, when considering solutions to change incidents, one team leader noted, "A lot of [solutions] are quite personal because a lot of what we are dealing with is the individual staff member's problems." The same respondent noted that time constraints, high workload, and high staff turnover made resolving these problems difficult.

Similar comments were made in several interviews and comments to this effect were handwritten on some questionnaires. For example, some nurse leaders treated people as individuals, but could not spend time teaching and coaching. Others were aware of the differing needs and aspirations of their staff, but were unable to develop their strengths because of systemic organizational constraints. Therefore, because nurse leaders *attempted* to provide much individualized consideration, but were often *unable* to provide it, we found great variability in the frequencies that were identified on the questionnaire. Consequently, we found high mean frequency, relatively high standard deviation, but certainly considerable variation in responses between the items that constituted individualized consideration. The items that explained the low reliability of MLQ factors were the items that helped to explain the uniqueness of the context in which leadership was repressed.

5.2. Emergence of categories at higher levels of abstraction

Many lower order categories appeared early in the coding process. Those lower order categories remaining after the completion of the theoretical coding are listed in Table 3. One example is the set of lower order categories that represent the higher order category, 'remembering history.' Early in the coding procedure, categories were identified that related to the family responsibilities of nurses, the role of nursing history in reinforcing their present professional culture, the educational levels expected of

Table 3
Hierarchy of abstraction schema of the basic social process and related categories

Basic social process and core category									Linked all categories; explained variation between near-core categories; identified very late in the analysis; results in theoretical explanation of the phenomenon
<i>Identifying paradox</i> (Component social subprocesses: legitimizing paradox and reconciling paradox)									
Near-core category					Near-core category				Categories which identify linkages between the higher order categories; identified late; emerge from theoretical coding
Process of repressing leadership					Multiple realities				
Higher order category Remembering history	Higher order category Role defining	Higher order category Leaving	Higher order category Above and beyond	Higher order category Supporting	Higher order category Organizational opaqueness	Higher order category Convoluting pathways	Higher order category Communicating	Higher order category Power rebalancing	Categories which subsume lower order categories at higher level of abstraction; identified midway; emerged from theoretical coding
Lower order categories Family	Lower order categories Technology	Lower order categories Turnover	Lower order categories Women's work	Lower order categories Informal networks	Lower order categories Visibility of structures	Lower order categories Cultural change	Lower order categories Making contact	Lower order categories Losing	Various properties associated; saturation achieved approximately halfway through study; emerged from open coding; some stay, some incorporated into higher level categories
Maintaining history Education Society Nursing	Relationships	Burnout Recognition	Loyalty Staff shortages	Formal networks		Continuity of message Continuity of relationships	Understanding Listening	Maintaining Gaining	
Properties Various	Properties Various	Properties Various	Properties Various	Properties Various	Properties Various	Properties Various	Properties Various	Properties Various	Constantly emerging

nurses, the role of nursing in society, and the nature of the nursing profession itself. During theoretical coding, it was found that these categories possessed similar characteristics in terms of their causes, consequences, characteristics, and interactions with other categories. Consequently, they were aggregated to form the higher order category called “remembering history.” Remembering history was found to have a role similar to that of four other higher order categories in contributing to the near-core category and social process of repressing leadership. More specifically, it became evident early in the data analysis and coding that leadership was not manifesting as readily in this environment as one would have expected. In fact, the emerging theme was a lack of leadership, more so than a manifestation of leadership. That lack of leadership was a function of “remembering history” as well as “role defining,” “leaving,” “above and beyond,” and “supporting.” Those higher order categories are all examined shortly within the context of repressing leadership.

5.3. *Repressing leadership—near-core category*

Repressing leadership was conceptualized from the lower order categories represented in Table 3. The higher order category of ‘remembering history’ has been discussed above. Similarly, changes to the profession have affected nurses’ understanding of their changing role. For example, when interviewed, one nurse team leader bemoaned “accountabilities for our budget, expenditure, patient satisfaction” and the resultant need to be “commercially oriented, as well as an expert clinician.” Another nurse manager regretted being “removed, more and more, from the bedside” and no longer carrying on a patient load. A third reiterated that if they “actually try to have a lot of contact with patients. . .it is your management parts that suffer.” Consequently, “role defining” was found to be another higher order category of *repressing leadership*. Space constraints prohibit the detailing of the remaining higher order categories associated with repressing leadership.

It was found that overcoming the effects of repressed leadership requires a cultural shift within nursing in order for nurse leaders to improve cohesion between nurse groups and improve nurse understanding and support for the changing role of nursing. This will allow nurse leaders to have more support from nurses to implement nurse-driven changes proposed by nursing literature within both nursing and the wider healthcare arena.

5.3.1. *Quantitative data*

Repressing leadership also explains the fact that many people who were perceived as transformational leaders, according to their MLQ profile, were unable to realize their potential for identifiable leadership impact. However, as the qualitative data analysis progressed, themes emerged from the data to support the interpretation that nursing leadership is affected by more factors than the leaders’ behavior. These themes are now considered from within the context of qualitative analysis of the MLQ data.

According to transformational leadership theory, laissez-faire leadership is the least effective form of leadership (Bass, 1985). According to our findings, nurse leaders were seen by many followers to display high levels of laissez-faire leadership. Accordingly, one could infer that they were not effective leaders. However, given the high workload of team leaders and the high number of meetings attended, respondents in interviews regularly noted that team leaders often display the laissez-faire behavior “absent when needed.” Furthermore, while nursing wards ran 24 hours per day, 7 days per week, the overall mean score of laissez-faire leadership in the nursing sample remained low in an absolute sense (0.8) and the factor was reliable ($\alpha=.8$). No individual items stood out, and therefore no individual

items required qualitative interpretation. Thus, most respondents appeared to take the context into account when answering the MLQ questions. For example, nurse respondents understood that it was physically impossible for their leaders to be available at certain times. Therefore, although nurse leaders attempt to display effective leadership as frequently as possible, the nature of the job and their relatively low levels of power mean that they are unable to do so as successfully as medical and administrative leaders.

Answers to laissez-faire items on the MLQ reflected this dilemma. Comments written on the MLQs provided insights into the leadership that was perceived by the respondents, and how the ability of those nurse leaders to demonstrate leadership was inhibited or repressed by the system within which they operated. For example, against the item “avoids making decisions,” one respondent wrote, “even if she makes decisions, she gets overruled!” Interpretation of these written comments was central to the grounded theory data analytic process. Nurses were attempting to communicate to the researcher information they felt was important. Therefore, the comments were considered to reflect nurse perceptions of important factors that the MLQ did not address. Such comments are invariably ignored in purely psychometric analysis of leadership. The high standard deviation for the laissez faire factor (0.94 on a scale of 0–4) indicated a considerable variation of responses, although the overall mean was relatively low.

Another factor of the MLQ, idealized attributes, highlighted the difficulties of interpreting a widely used questionnaire on the present organization. This factor also highlighted the political nature of the leadership phenomenon in the substantive setting under investigation. One item in the idealized attributes subscale was “displays a sense of power and confidence.” The lack of power and repression of leadership in nursing has been argued qualitatively in the present study. Therefore, although respondents acknowledged that they saw nurse leaders attempting to display a sense of power and confidence, these displays seldom reached fruition. Consequently, the relatively high mean frequency of the behavior (3.1) was moderated by the lower reliability coefficient for the factor of $\alpha = .68$. Removal of the item “displays a sense of power and confidence” was found to increase the reliability coefficient to an acceptable $\alpha = .72$.

Whether it comes from structure or from hierarchy, access to power (especially position power) is critical to one’s ability to realize leadership outcomes (Yukl, 2002). The inconsistency with which nurse leaders are perceived to demonstrate leadership is in itself a finding. This is not a fault of the MLQ, but a function of the political and organizational environment within which they operate. Nurse leaders appear to attempt to demonstrate high levels of idealized leadership, but the politicized environment within which they operate means that they cannot do it consistently. In particular, this challenge relates to their ability to display a sense of power and confidence.

The intellectual stimulation factor also had a low alpha coefficient of $\alpha = .58$. One representative question, “seeks differing perspectives when solving problems” explained most of the low reliability of this factor. This item reflected the conflict within nursing between traditions of hierarchy and procedure and the newer perspectives of change toward empowerment and autonomic excellence. For example, the report for the [Ministerial Taskforce on Nursing \(1998\)](#) argued that nursing is unable to move forward because of resistance within nursing. The mean score for the intellectual stimulation category (2.9) was significantly higher than the national norms. This could be because of the greater awareness among nurses for the drive for nursing culture to become more innovative and open to change despite considerable internal conflict. However, once again, although they attempt to display this form of leadership frequently, they cannot do it consistently. In particular, in the present case, many subjects

found it difficult to seek differing perspectives when solving problems. Such a finding supports the presence of the higher order categories of “remembering history” and “role defining” in particular.

The transactional factor, contingent reward, had a reliability of $\alpha = .61$ and a mean score of 3.0. One item measuring contingent reward behavior was, “provides me with assistance in exchange for my efforts.” This item explained most of the low reliability. It was considered qualitatively in terms of the high workload team leaders faced. Sometimes, it was impossible for a team leader to provide the level of assistance nurses required, due to their high workload and lack of formal power. However, the low reliability could reflect respondents’ understanding of the situational factors inhibiting the display of contingent reward behavior.

The two other transactional leadership factors of management-by-exception active and passive provided more reliable results. This could be because such transactional behaviors were traditionally supported by the nursing culture. Nursing practice remains highly procedural and the management-by-exception categories reflect this culture. This is especially reflected in the high frequency of management-by-exception (active) behaviors. Because of the importance of monitoring and controlling for the safety of patients, nurse leaders display this behavior 19% more frequently than do New Zealand managers generally.

The quantitative approach of the MLQ provides the present study with greater scope for analyzing the leadership processes in a changing organization. The MLQ and interview data provided contrasting views of nurse leadership in the context of a complex and changing organizational environment. The results also suggest that the study of nurse leadership needs to incorporate the wider context in which the leadership occurs in addition to the behaviors demonstrated by the individual. The MLQ certainly provided a better understanding of *repressing leadership* in nursing, and this was only achieved when the results were examined qualitatively in conjunction with other data.

However, nurse leadership also needs to be considered in the broader organizational environment. This is because nursing is not an insular profession. Nurses are a part of the wider healthcare industry and must work closely with other health professionals to maximize patient outcomes. The anomaly that nurse managers could display transformational leadership within an environment of repressed leadership was partly explained by the emergence of another near-core category, that of *multiple realities*.

5.4. *Multiple realities—near-core category*

As well as the identification of the process, *repressing leadership*, it became apparent at the middle stages of analysis that three main groups of hospital employees each perceived different realities about the nature of the change process and its impact on the manifestation or otherwise of leadership. The salient groups recognized were nurses, managers (or hospital administrators), and doctors. Understanding the *multiple realities* of these three groups played a large role in understanding the phenomenon of leadership under investigation. As Table 3 shows, early in the data analysis, some other lower order categories became apparent. Theoretical coding of these categories showed that they had conceptual similarities and consequently could be aggregated together into the higher order categories of “organizational opaqueness,” “convoluting pathways,” “communicating,” and “power rebalancing.” Collectively, these higher order categories represented the near-core category *multiple realities*.

Although the present study originally aimed to study nurse leaders, nurse respondents frequently referred to “doctors” and “management” as affecting nurse leadership. Therefore, the relationships

between these three groups (medicine/doctors, nursing, and management/hospital administration) were investigated in the context of nursing leadership through organizational change.

Multiple realities is a higher order category explaining the variation in perceptions between various subcultures within the hospital environment affecting organizational change efforts and nursing leadership. The variance in perceptions is closely linked to power structures present in City Hospital. The historical role of nurses as subordinates to doctors and management encouraged a culture not supportive of collaboration or a collegial relationship between the groups. Nursing is a female-dominated profession, whereas medicine and management are still male dominated. This issue further strengthened the separation between these groups.

Members from each group regularly cited incidents highlighting a lack of understanding between the groups. Comments made by nurses provide evidence for a lack of understanding by management of salient nursing issues. For example, nursing staff frequently made comments, like "...I don't know if they understand the extent of the problems here," "...they just don't understand. . ." and "...they will just not look"

In another example, the focus on financial issues by the nonclinical (management) staff and a concomitant focus on client care issues by clinical (nursing) staff were found to cause tense disagreement. Although both groups aimed for the same goal of an effective organization, including excellent client care, each group's understanding of the other group's issues was found to be limited or disregarded. One related lower order category was labeled "power rebalancing." This category addressed the issue of the historic imbalance of power between nursing and the profession of medicine. An example of this dilemma came from a staff nurse when she said,

One of the things that was always a problem everywhere is the dominance of medical staff who go around and criticize what nurses are doing. . .don't listen to what nurses say about the patient and make summary decisions that usually aren't appropriate for the patient anyway. But when a nurse tries to stand up and say, 'That's not right', they are ignored.

Power rebalancing was found to parallel the other lower order categories 'organizational opaqueness' and 'convoluting pathways' (see [Table 3](#)).

'Organizational opaqueness' accounted for the confusion and lack of clarity about organizational systems and structures, which impacted on nurse leaders' ability to implement change. One example of the puzzlement with management processes came from a nurse leader who claimed to be constantly "battling" with management to achieve "a reasonable level of care for all patients and on occasions I have to say we're actually unsafe." Another charge nurse complained about having to "collect enough information and examples of when we're unsafe to be able to convince the management team who are providing the funding. . .that we need more staff." It was apparent that the lack of positional power available to nurses reduced their ability to realize desired outcomes through the use of political leadership.

'Convoluting pathways' within the larger environment of organizational opaqueness accounted for the different foci of the three professional groups. For example, many nurses and doctors lamented the lack of continuity in communication and relationships that came with continually changing structures, personnel, and cultures. Without the formal power that doctors and managers possessed, nursing staff had to continually "tread a new path to the door of some new manager" to achieve outcomes that they

sought. The results of convoluting pathways could be seen in the conflicting ways in which the groups would attempt to implement change.

Finally, “communicating” was found to be a moderating variable in the acceptance of nurse leader change efforts. As an almost ubiquitous precursor to leadership success or failure, the communication challenges associated with multiple realities were typified by the perceptions found in this research that “the communication from the top down about organizational changes is inconsistent and poor.” Another nurse manager said,

There has been no discussion whatsoever with [management]. It is just a piece of paper that comes out and says that your title is now this. There is no discussion, no ‘what does this mean? Does this mean I still have a job? Who am I? Where am I going?’ That is always done badly here. And it happens every time.

It is important to note that change resistance from within nursing is also responsible for repressing nurse leaders’ ability to move nursing toward visions of autonomy and collaboration. In addition, high covariance was found between the two near-core categories of *repressing leadership* and *multiple realities*. In effect, their relationship was found to be reciprocal. This is because nursing culture both influences and is influenced by other cultures within the hospital. However, in order to more fully explain the leadership process and to account for all the variation, a higher level category was needed that would subsume these two covarying near-core categories. The key to that core category came with the realization of the ubiquitous influence of paradox in the sense making of nurse leaders.

The main issue facing nurse leaders was coping with the concurrent changes to the culture of nursing and the increasingly turbulent environment of the hospital. Throughout these changes, nurse leaders were not only required to continue to provide excellent healthcare, but to enhance the position of nurses in the organization and maximize positive health outcomes.

5.5. Core category—*identifying paradox*

Identifying paradox emerged as the highest order category by which all similarities and variation in leadership behaviors and interactions could be explained. Thus, *identifying paradox* met the criteria for being described as the core category. *Identifying paradox* also met the criteria for being labeled a basic social process because *identifying paradox* occurred over time, under various conditions (Glaser & Strauss, 1967). Fig. 1 is a representation of the relationships between these categories in terms of their hierarchy of abstraction. The hierarchy of abstraction model was posited by Parry and Meindl (2002) as a way of displaying the relationships between emerging categories as they emerge at progressively higher levels of abstraction. Apart from being an effective way to represent the present findings, Fig. 1 could also become a testable factor model for subsequent replicative structural equation modeling, as per the example of Parry (2002).

5.5.1. *The paradox*

In the context of the present study, paradoxical interpretations were identified in interviews when respondents discussed relationships and incidents. ‘Paradox’ described contradictions or inconsistencies occurring throughout interview responses. The creation of paradox was found to stem from the divergent

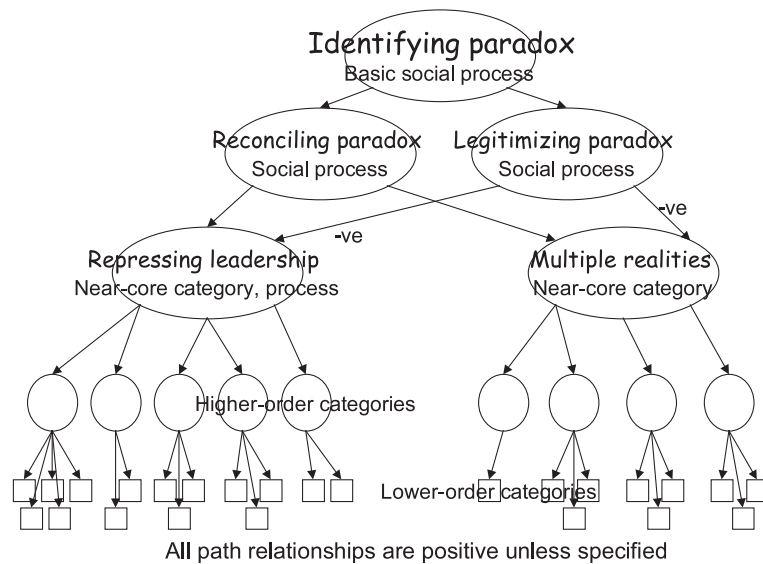


Fig. 1. 'Identifying paradox': hierarchy of abstraction model.

multiple realities of the three very different cultures of medicine ("doctors"), nursing, and management. Further divergent realities within nursing were also found to create paradoxical understandings.

The term paradox is used in conjunction with three verbs: identifying, reconciling, and legitimizing. *Identifying paradox* refers to the implicit recognition that the situation and understandings of the respondents were paradoxical, and that those paradoxes could be either reconciled or legitimized. *Reconciling paradox* refers to the resolving of the paradoxical understanding. Insofar as it gives meaning where uncertainty exists (Ferris & Judge, 1991), reconciling paradox is axiomatically characteristic of political behavior. In effect, this represents the demonstration of leadership. *Legitimizing paradox* describes the process by which respondents did not consciously identify the paradox and made the paradoxical argument sound legitimate on the surface. In effect, therefore, legitimizing was found to repress leadership.

Paradoxical discourse was found to occur most often when respondents discussed change efforts that had caused conflict and misunderstanding for them and others. More specifically, the conditions under which paradoxical discourse most often took place were when respondents described change incidents or relationships that involved others with divergent realities. Paradoxical discourse also occurred as respondents attempted to justify their position over that of others. There was no evidence that people use ambiguity or brinkmanship intentionally (Fairholm, 1993) as an unsanctioned form of political behavior. Rather, there was an inability to reconcile paradox in one's own mind, let alone in the minds of the target audience. Again, this echoes of divergent *multiple realities*, but more specifically of attempts to gain power or status in order to maximize one's own position.

5.6. Basic social process—identifying paradox

The basic social process of *identifying paradox* explains the social process by which the staff either *legitimize* paradoxical understandings that were created from the multiple realities of the three major

subcultures working in the hospital setting, or they identify and *reconcile* the paradoxical understanding. The social process of legitimizing paradox has been modeled as a spiral in which leaders may intervene at any point along a temporal continuum to either reconcile or legitimize paradox to converge or diverge the multiple realities that followers are experiencing. The identification and subsequent reconciliation of paradoxes were found to support positively perceived changes and the convergence of multiple realities. The opposite effect occurred when legitimizing paradox occurred. Realities between different groups became divergent and subsequent changes were more likely to be perceived as negative. Fig. 2 presents a model representing these two subprocesses.

The process model in Fig. 2 includes a detail of a section of the spiral to show the impact of leadership through continuous cycles of change. Two spirals denote a temporal continuum over which organizational changes take place. Actors may perceive organizational changes as positive or negative. Depending on the way in which the change is perceived, change is either followed by the legitimizing of paradoxes and the subsequent divergence of *multiple realities* or the reconciling of paradox and subsequent converging of *multiple realities*. Each spiral reflects a subprocess contained within *identifying paradox*. The upward spiral arrows represent the positively perceived change outcomes occurring when the repression of nurse leadership is overcome. The effects of nurse leadership on organizational changes include a reconciliation of paradox, converging *multiple realities* and positively perceived change. The downward arrows represent the downward spiral denoting the effects of

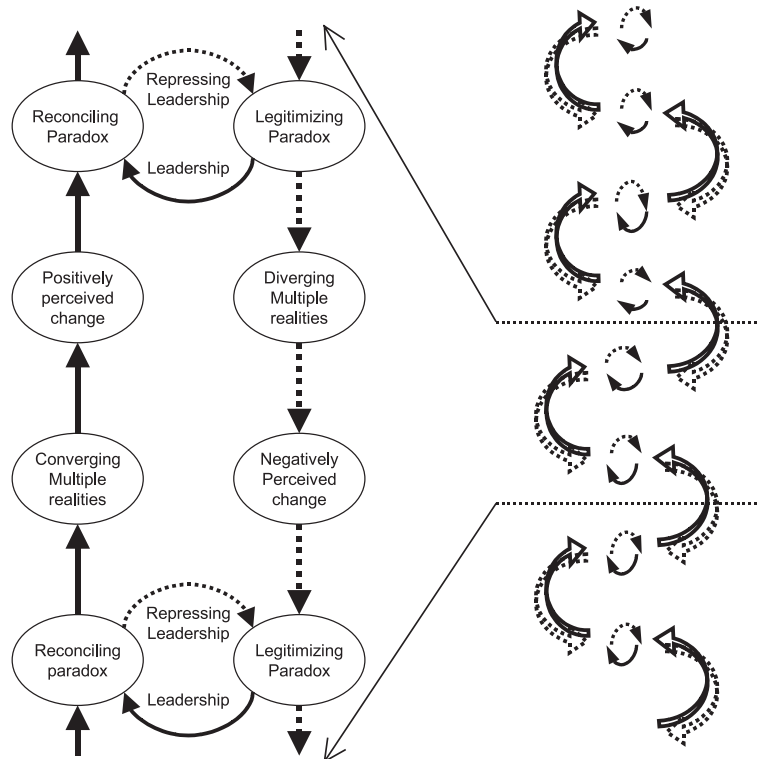


Fig. 2. “Identifying paradox” process model.

repressing leadership. The divergent *multiple realities* lead to negatively perceived changes, leading to legitimizing paradox.

One important aspect of the model is that it is dynamic. That is, the process is occurring constantly and that it is occurring concurrently at several places at once. For example, one group's negative perceptions of a change could follow the downward spiral while another group's perception of the same change could be positive, following the upward spiral. However, the intervention of some further change event could trigger different interpretations of the paradoxes being faced by the staff.

The spiral arrows also represent a temporal dimension in the model. Different incidents follow different time frames as they occur within organizational change incidents. For example, one micro-incident could reflect the reconciling of a paradox within the context of a meso- or macroincident that represents the legitimizing of paradox. However, the relative speeds at which changes occur have not been investigated in the present study beyond the acknowledgement that changes are generally situation specific.

The following two sections discuss in detail the two subprocesses within the paradox model. These are legitimizing paradox and reconciling paradox. Along with detailed descriptions of both these subprocesses, an example of the change incident 'ward pay rise' will be followed through the legitimizing and reconciling subprocesses to illustrate the way in which the model in Fig. 2 deconstructs the complexities of respondent perceptions of an organizational change effort.

5.7. *Legitimizing paradox: a subprocess*

5.7.1. *The ward pay rise example—a representative critical incident*

Several critical incidents occurred during the time within which data were gathered and analyzed. To discuss all of them would be too time consuming. Instead, the incident of the pay rise is used herein as an exemplar of the incidents within which the paradoxes and processes were represented.

In addition to hospital-wide high turnover and nursing staff shortages, one unit was suffering higher than usual turnover and staff dissatisfaction. This unit had also been through a major external review and subsequent staff restructuring. Eventually, both clinical (nursing) staff and management recognized that the unit was still not functioning and was at 'crisis level.'

Hospital management and the nursing team leader negotiated a 7% pay rise for nurses in the unit, bringing their pay rates abreast with other hospitals around the country. As a result, turnover decreased and nurses considered the ward to be improved and functioning more effectively.

Prior to the pay rise, the discourse among respondents supported all nurses receiving higher pay. Some nurse respondents outside the pay rise ward made reference to the work the pay rise nurses performed as being outstanding and difficult. A representative comment by a team leader was,

I'm in awe of my colleagues in [the pay rise ward]. You know, I stand back and see what they're doing, and OK, people say that's not nursing that's just technology but, I mean, there's always a patient at the end of the technology.

However, after the pay rise, the same respondent noted in an informal interview that the pay rise was unfair and those nurses had no right to more money when other nurses worked just as hard and experienced similar working conditions. The respondent's response was typical of nurse responses to the situation.

Nurse respondents who did not get the initial pay rise described the inequitable situation paradoxically because the solution to the pay rise ward's problems appeared, to them, to be solved irrationally. The concomitant defense of the pay rise by nurses within that ward also resulted in nurses resorting to paradoxical answers when defending their pay rise over nurses in other wards.

It was found that the underlying cause of respondents using paradoxical statements is to enhance their own position through a time of perceived inequality and change. However, to strengthen an individual position, respondents regularly referred to others who worked with them. Generally, nurses viewed other nurses they worked with as potential allies, and therefore included examples of how their colleagues worked to strengthen their arguments.

The downward spiral demonstrates the subprocess legitimizing paradox from the perspectives of nurses who did not receive the pay rise. Nurse leaders in other parts of the hospital were initially unable to negotiate the same pay rise for their staff. The inability of these nurse leaders to secure a pay rise for their staff was considered to be the result of repressing nurse leadership by groups outside nursing. Therefore, as nurse respondents learned of the situation, nurses and their nurse leaders viewed the situation as inequitable. This could be viewed as a negatively perceived change, a perception that moved through the organization as all wards learned of the pay rise.

The initial consequence of the pay rise in other wards was paradoxical discourse by both groups of nurse respondents within and outside the pay rise ward, aimed at maximally justifying their own perspective. This stage was identified as legitimizing paradox.

The continued legitimizing, coupled with the inability of nurse leaders to improve the situation for their nurses (more *repressing leadership*), led to divergent *multiple realities* within nursing and between nursing and management. This led to more negatively perceived change, resulting in a hospital-wide nurse strike in which striking and nonstriking nurse respondents continued to make paradoxical statements. The vicious cycle continued until the strikes led to a smaller pay rise for the striking nurses.

The nurse strike led to the danger that client safety could potentially be compromised. Therefore, the opposing groups of management and nursing finally reached an agreement, which was positively received by the nurses. This phenomenon is what Block (1987) and Ammeter et al. (2002) would explain in terms of organizational politics as an idealized future being attained through the cooperative efforts of the collective. At this point, it is salient to consider the upward spiraling subprocess, reconciling paradox.

5.8. Reconciling paradox: a subprocess

5.8.1. The ward pay rise example revisited

The multiple realities of the pay rise strike were largely based around the perspectives of 'management' and 'nursing.' It was found that as both groups worked to improve the functioning of the hospital, rather than to achieve their own individual goals, the divergent realities of the two groups began to converge. That is, management recognized that a pay rise for the rest of the nurses could improve the functioning of the hospital, which was a goal for nurses as well. The smaller pay rise for the nurses also led to the nurse perception that they were gaining some recognition for their work. In effect, a coalition (DeLuca, 1999; Stevenson, Pearce and Porter, 1985) was formed between management and nursing. This constitutes political leadership. What is unfortunate is that the antecedent context had to become so bad before this leadership was enacted.

As organizational changes are perceived more positively, *multiple realities* can further converge. Paradoxes become less frequent and more easily reconciled between those convergent realities. This positive cycle may continue as long as groups perceive situations similarly.

6. Conclusions and implications

The present study offers implications for nursing practice, nursing leadership, and leadership research. These implications shall be discussed in terms of the achievement of the objectives of the research. The first objective of this research was to bring quantitative psychometric data into grounded theory analysis. This is an innovation which hitherto has been lacking in grounded theory research. Mainstream research practices in leadership have traditionally tended to control for variables, such as hierarchy or groups, to comply with the positivist nomothetic tradition. By contrast, central to the grounded theory method is the emergence, rather than the testing of theoretical propositions and phenomena. Moreover, abstract concepts, such as paradox and sense making, have traditionally been difficult to measure with mainstream leadership research methods. However, by bringing quantitative data into the holistic analytic approach of the grounded theory method, the richness of these leadership phenomena have been more fully illuminated.

In common with the implications for nursing, the implications of the present study for leadership research revolve around the notion that leadership is a dynamic process occurring in dynamic contexts. Holistic methodologies, such as grounded theory, can generate insights into these processes. More importantly, the triangulation of data within the grounded theory method will assist the researcher in generating more complex and explanatory insights into how the process operates. In particular, the contrast in findings between the qualitative and quantitative data forced the researchers to engage in further iterations of theoretical coding to explain in abstract the nature of the contrast and what the implications were for the leadership process.

The second objective of this research was to better understand the leadership processes operating within the nursing environment of a hospital undergoing organizational change. A major emergent focus of the present study was the group dynamics between nurse leaders and nurses, and between nurses and the two other professional groups within the hospital. As part of the theoretical sampling in this study, nurses across all hierarchical levels were formally interviewed, observed, and surveyed. People from the other professional groups were also interviewed.

A recurring theme in this study was that nurse leaders had the potential to achieve greater influence and change within the healthcare environment. However, an equally recurring theme was that this potential was repressed by cultural and societal factors within and outside nursing. The occasionally vicious cycles of resistance to negatively perceived change sometimes resulted in nurse leaders repeating the same steps that resulted in resistance in the first place. Similarly, nurse-driven changes were resisted by other groups, and sometimes, by nursing itself. The consequences were the perpetuation of negatively perceived change and of continued conflict. *Reconciling paradox* tended to reflect some of the sanctioned political tactics identified by Zanzi and O'Neill (2001). These tactics include networking, coalition building, and rational persuasion. By contrast, *legitimizing paradox* tended to reflect some of the nonsanctioned political tactics—especially manipulation, intimidation, control of information, and blaming others.

The need for nurse leaders to have more influence within healthcare systems was recognized by several prominent reports (World Health Assembly, 1989; World Health Organization, 1996). The findings of the present study also support the need for nurse leaders to have more influence within the organization. However, it is not enough for studies to express the need for more collegial work practice, for a favorable culture, and for nurse leaders to be more proactive and committed, as do several reports identified in the present study (Irurita, 1996; World Health Assembly, 1989; World Health Organization, 1996). It appears that nurse leaders need to have greater power to influence the perceived realities of the stakeholders they seek to influence. Without that power, they will continue to have their leadership potential repressed.

During and immediately following the present research, nurse leaders locally and nationally were attempting to address perceived inequalities through changes to internal systems, and through escalating industrial action nationally. Resorting to industrial action is seen as a regrettable last resort when other political actions have been either absent or unsuccessful in improving perceived inequalities or improving a power base.

The third objective of this research was to determine the basic social process reflecting those leadership processes. The basic social process of *identifying paradox* does not provide an all-encompassing formula for effective organizational change. However, it does explicitly identify the underlying causes of the present issues for nurse leaders and offers an in-depth insight into the processes leading to both negative and positive perceptions of change efforts. The subprocesses of legitimizing and reconciling paradox promote a greater understanding of the dynamics between subcultures within the organization. To the extent that effective leadership is a process that reconciles paradox, it is conceptually similar to Weick's (1995) sense making, Smircich and Morgan's (1982) notion of leadership as the management of meaning, and Ammeter et al.'s (2002) notion of organizational political leadership as the management of shared meaning.

Whether or not reconciling paradox is an intentional strategy of a 'leader,' it is an inherently necessary component of organizational functioning, in the same way that organizational politics is inherently necessary (Pfeffer, 1981) and a reality of organizational life (Ammeter et al., 2002). Legitimizing paradox is equally a reality of organizational life, and is fed by the antecedent characteristics of leaders and of the target audience (Ammeter et al., 2002), as much as by the political behaviors of leaders.

Moreover, paradoxically, much of the extant literature's calls for nursing leadership have revolved around improving client care while simultaneously cutting costs. These calls have contributed to a situation of continuous and complex change. It appears that future nurse leaders need to reconcile this and other paradoxes in the minds of their followers in order to move the profession forward. Part of that reconciliation seems to include an increase in the organizational power base of the nursing function. Political leadership will be needed to achieve this.

The fourth objective was to generate a theory explaining the phenomenon of nursing leadership within this environment. Just as *identifying paradox* is a basic social process that explains leadership in this substantive setting, it is also a theory which contributes to our collective understanding of the phenomenon of leadership, especially when attempting to move associates through a change process toward some collective goal. Further replicative research needs to be conducted on the present substantive theory to generalize these findings to other areas. The present research has shown how useful the full grounded theory method is in providing new insights from alternative angles to well researched areas.

Appendix A. Introductory questions asked in semistructured interviews

These are indicative questions only. The exact wording, and the wording of intervening and supplementary questions, is determined by the direction of the interview and the responses of interviewees.

A.1. Questions relating to leadership processes occurring in critical incidents

- What are the major changes that are affecting you at the moment?
- How do these changes affect your motivation, attitude to work, performance?
- Who has had most effect in creating, driving or stifling these changes?
- How have they had that effect?
- What effect have you had on these changes?
- How have you had that effect?
- Do exceptional people stand out as affecting your application, motivation, or your ability to get things done?
- How have they had that effect?
- How have you had that impact on others?
- Who has had most influence on you in this organization?
- How have they had that effect?
- Who do you look up to and whom do you follow?
- How do they get you to do that?
- How do you get people to look up to you and follow your lead?
- Who do you look to, to get you through the change process?
- How are they going to get you through the change process?
- Are there people you would do that bit extra for?
- How do they get that bit extra from you?

Intervening and supplementary questions related to

- expanding and giving detail on incidents, processes, and the impact of particular people.
- specifying the role of people at senior and junior levels in the organization.

A.2. Questions relating to implicit theories and their effect on values

- What does leadership mean to you? What is your philosophy of leadership?
- Have you seen evidence of such leadership in this organization recently?
- How has this leadership been evidenced?
- Compare and contrast two obvious leaders in the organization.
- Can you think of examples where leadership is obviously lacking?
- How and why is it lacking?
- If you were running a leadership course in this organization, what content would you include?

Theoretical sampling dictated that subsequent and ongoing questions be directed at particular people, and about particular incidents; with the aim of clarifying and saturating the nature of concepts, and the theoretical relationship between concepts.

Key incidents were identified early in the interviews. Key people were also identified. They were often not referred to by name, in an attempt to maintain confidence in the confidentiality of the interview, and to enhance the richness of the responses. Once key incidents and key people had been identified, the detail of leadership processes was examined. This is reflected in the abundance of “how?” and “why?” questions. These questions are important for understanding and theorizing about process.

Source: adapted from Parry (1999).

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