

The nurse executive: challenges for the 21st century

M. FEDORUK¹ MHA, BAppSci(Nsq), DepAppSci, CCRN, RN and J. PINCOMBE PhD, MAPSC, BA, RN, RM²

¹Student and ²Professor of Nursing, Faculty of Nursing, University of South Australia, Adelaide, Australia

Correspondence

M. Fedoruk
55 Forest Avenue
Newton
South Australia 5074
Australia

FEDORUK M. & PINCOMBE J. (2000) *Journal of Nursing Management* 8, 13–20

The nurse executive: challenges for the 21st century

Aim The aim of this paper is to examine the challenges facing the nurse executive in the 21st century by questioning the traditional attributions of leadership to the nurse executive role.

Background Historically, the leadership role in nursing has been assumed by the nurse executive. The predominantly female character of nursing, however, has ensured that demonstrations of leadership amongst nurses have been infrequent and compatible with prevailing male-defined ideologies. Examples of this include career restructuring and educational reforms in Australia.

Findings This paper found that the apparent lack of leadership in nursing was able to be traced back to early management theories which categorized leadership as a function of management.

Conclusions If nurses are to assume leadership positions in the health care system of the 21st century, nurse leaders will have to let go of traditional managerial practices and behaviours. In the emerging health care system of the new century, nurse executive practices will focus on achieving change rather than predictability in organizational outcomes.

Accepted for publication: 6 September 1999

Introduction

Historically, the leadership role in nursing has been assumed by the nurse manager/executive (Henderson 1995). The early nurse executive came from a different social class than the bedside nurse, and this class differentiation has been a feature of the discipline of nursing since Nightingale's time (Godden 1995). Criteria for appointment to the nurse executive position included social status, educational preparation, particularly in household management and acceptance by the dominant groups working in health care agencies, namely male administrators and doctors (Ashley 1976, Godden 1995). The entry of men into nursing has simply resulted in the replication of gendered arrangements within the working

sphere (Evans 1997). The predominantly female character of nursing has ensured that demonstrations of leadership amongst nurses are infrequent and compatible with prevailing ideologies, e.g. career restructuring and educational reforms (Gardner & McCoppin 1989).

This apparent lack of leadership in nursing, suggests that the attribution of leadership qualities to the nurse executive may, in retrospect, have been misplaced. Early management theories identified leadership as a function of management, and nurses turned to these theorists to develop a management role within nursing. Yet these early management theories were designed within a masculine paradigm using the language of men (Muller & Cocotas 1988).

Like their counterparts in corporate management

positions, nurse executives have attempted to fit the nurse manager role to male prescriptions, resulting in what Petersen (1993, p. 243), has labelled 'partial men'. Still, Guerin and Chia (1992), in their studies of women in the corporate sector have observed that adaptation to the male management paradigm has resulted in the phenomenon of neutered women.

The management–service gap

The concept of the management–service gap describes the divide between the nurse at the bedside and the nurse executive. The existence of the management–service gap can be traced back to the historical and enduring pervasive image of the nurse at the bedside (Strauss 1966). The nurse executive, by virtue of function and location, is distanced symbolically and functionally from the bedside nurse, is patient free and therefore, has stepped outside of the socially prescribed roles for women and nurses. The management–service gap has created the 'pseudo nurse', who is perceived by bedside nurses to be irrelevant and nonessential (Humm 1994). This lack of relevance is now being further put into question by managerialist policies which favour the continuance of the male management role in health care (Clay 1987).

Following the restructuring of the National Health Service (NHS), the United Kingdom in the 1980s, 18 000 administrative positions were created and 8000 nursing positions were made redundant (Fatchett 1994). Where senior nurses retained their positions they were systematically edged out of decision-making positions (Owens & Glennerster 1990). As a consequence, the nurse executive was made powerless and ineffectual.

This marginalization of the nurse executive has meant that, in order to be heard or be considered as a significant player in the health care system, the nurse executive has had to learn and adopt the language and behaviours of the dominant groups, weakening their association with nurses and thereby separating them even further from the nursing workgroup (Roberts 1997).

The nurse executive is therefore marginalized on several fronts: (1) from the nursing workforce, who do not see the relevance of the role; (2) from a male management culture because of gender; and (3) a perception, that the educational preparation of nurses is inadequate for success in senior management roles in health. Yet, a comparison of educational qualifications between nurse executives and comparable lay managers demonstrates the pre-eminence of formal qualifications amongst the nurse executive group (Hockley 1990). Similar findings were reported by Still *et al.* (1992), in their study of women in corporate executive level positions. Palmer and Short

(1989), comment that there is no requirement for lay managers to be licensed to practise, following a recognized course of study, as are professional health care workers.

The resocialization of the nurse executive into a male management culture intensifies the separation between the two groups of nurses, the bedside nurse and the nurse executive, with the nurse executive being perceived as a member of an elitist group, who have reached their position because of their allegiance to the maintenance of the status quo (Irurita 1990; Roberts 1997). The nurse executive has so internalized the values and belief systems of the new peer group, that all decision making appears to be based on these factors.

Many nurse executives become 'Queen Bees' and, whilst ostensibly representing nursing, will vote against nurses and their concerns in order to maintain their positions (Halsey 1978, p. 271). The 'Queen Bee', will also work to minimize any potential threat to her hard-won position and status, by blocking the career pathways of other nurses. The rewards received by the nurse executive, also make her reluctant to step outside her prescribed supportive role to the generic managers, to act in the best interests of nurses and nursing. These behaviours lead to a divisiveness in nursing, which makes it easy for non-nursing groups to control the whole of nursing (Muff 1988). The use of professional managers is a strategy employed by lay managers and politicians to control the activities of a professional workforce (Harrison & Pollitt 1995).

Leadership and management: two discrete concepts

For most of this century, leadership has been considered as a function of management which, in nursing translated to nurses being over-managed and under-led, making them vulnerable to the strategies of managerialism (Greenwood 1997). The perceived lack of leadership in nursing, has made nurses inadvertent bystanders to the degradation of social policy and the implications of this for quality health services delivery.

Nurses are the largest workgroup within any health care system, yet nurses have tended to be excluded from decision and policy making forums in health care (Borman & Biordi 1992). This may be attributed to the gendered and occupational socialization processes which nurses undergo, internalizing on the way, dominant societal perceptions which devalue their personhood and their labour (Condon 1991). The socialization processes may also account for the fact that the nurse executive role extends within nursing, but does not expand within the health care system (White 1984).

Role extension describes the delegation of tasks from a dominant group to a more inferior group. Perhaps the best example of role extension in nursing is seen in the delegation of medical tasks, because this has been seen as a status enhancer (Game & Pringle 1983). Similarly, nurse executives have accepted extended portfolios of organizational managerial responsibility, reflected in titles such as 'Director of Nursing and Extended Care Services' and 'Executive Director, Nursing and Client Services'.

These role extensions have occurred because of corporate restructuring of health care services, as well as the current industrial award requirement for a designated head of a nursing service; an issue which is now being challenged by both bedside nurses and lay managers looking to consolidate the male management ethos within the health care environment (Clay 1987; McDonagh 1998). Role extensions for the nurse executive have resulted in a strong identification with the male management culture (Still *et al.* 1992).

The extended role of the nurse executive merely acknowledges the managerial expertise of nurse executives within carefully prescribed parameters supported by occupational flattery (Muff 1988). Consequently, the nurse executive is perceived by other nurses as an agent of the organization with little or no relevance for nurses or nursing issues (Halsey 1978; Roberts 1997).

Role expansion for the nurse executive on the other hand, would have seen the nurse executive assume and enact a leadership role not only within nursing but the global health care system. This would require changing a cultural mindset which identifies nurses and therefore nurse executives as secondary players in health care organizations and sectors (Condon 1991).

In an expanded role, the nurse executive would focus on health services delivery to a population, as opposed to the current situation which is the provision of nursing services to a discrete medically defined consumer group. The nurse executive is ideally placed to assume a leadership role in population-based health services delivery for two reasons: (1) the educational preparation of nurses emphasizes holism; (2) nursing is practised within a managerialist framework (Gilmartin 1998).

Nurse executives make good managers; they have been socialized to accept direction and to give direction within prescribed parameters and like all nurses, nurse executives are well-trained women (Muff 1988). The nurse executive role was formalized within health organization structures because of Nightingale's insistence that nurses be managed by suitably qualified nurses. In retrospect, it could be argued that this particular demand of Nightingale's was agreed to because it ensured the supply of a cheap and renewable labour force. Bayly (1987), points out that the

accounts of nursing history were ideologically correct, rather than a record of reality.

Demonstrations of leadership in nursing, have been infrequent, ever since the institutionalization of nursing in the 19th century. Early examples were the push for certification and licensure which were opposed by Nightingale (Johnstone 1994). More recent examples include the educational reforms and career restructuring for nurses. Educational reforms for nurses for instance, began to be implemented in the 1970s, following 20 years of negotiation with key stakeholders, and introduced by a federal government, sympathetic to expanding educational opportunities for women (Gardner & McCoppin 1989). Towards the end of the 20th century, however, there are now politically motivated calls to re-introduce hospital-based nurse training programs (ANF 1998, p. 12).

Career restructuring for nurses in Australia, was similarly introduced, following protracted negotiations with governments and colleagues, but there is evidence to suggest that the clinical and management roles in nursing are now being combined as part of a broader managerial agenda to return nursing to the bedside. The occupational development of nursing has always been dependent upon governmental support and sanction, as are other state-run services and agencies. Nursing, therefore, has always been susceptible to the vagaries of political pragmatism and 'economic constraints' (Forsyth 1995, p. 165).

Synonymous use of the terms 'leadership' and 'management' have proven to be problematic for nurses and particularly for the nurse executive who has been prepared within a managerialist framework (Duffield 1994). The dilemmas for the nurse executive arise when they are confronted by what Badaracco (1998, p. 111), describes as 'defining moments'. At such times the nurse executive must balance the demands of corporate reality with personal and professional idealism. Achieving this requires the translation of an ethical vision into a calculated action which has the support of other workers. In other words, the nurse executive must use these defining moments as opportunities to enhance and redefine the health system and organization's role in society (Badaracco 1998, p. 107).

Redefinition of the nurse executive's organizational role can only occur once the terms 'leadership' and 'management' are understood and accepted as separate and discrete concepts within the collective consciousness of health care agencies (Greenwood 1997).

Table 1 compares the concepts of leadership and management and clearly shows the conceptual and functional differences between leadership and management. When Nightingale reformed nursing in the 19th century, she insisted that nursing and nurses be managed by a suitably

Table 1
Management and leadership two discrete concepts

<i>Actions</i>	<i>Management</i>	<i>Leadership</i>
Creating and agenda	Planning and budgeting Setting timetables and targets Allocating resources	Developing long-term visions Developing strategies for producing change
Developing a human network for achieving coalitions and teams the agenda	Organizing and staffing Developing policies and procedures	Aligning people Creating
Execution	Creating a structure Monitoring and supervising Controlling and monitoring Identifying problems	Communicating vision Ensuring understanding Motivating and inspiring Overcoming political, bureaucratic and resource barriers Developing staff to fullest potential
Outcomes	Predictability	Change

Adapted from Kotler (1994).

trained nurse, preferably a woman used to managing servants (Dingwall, Rafferty & Webster 1988). The social class structure which defined Victorian society clearly separated the nurse executive and the practising nurse (Godden 1995). The role of the nurse executive in 19th century health care facilities was to maintain social order, in the health care agencies through the control of nurses' behaviours and by acting as a transmitter of information between the dominant groups and the nurse at the bedside. Belonging to the right social class facilitated this process (Godden 1995). An unwritten postscript to the nurse manager role was the insistence of deferential behaviours from the rank and file nurses towards the socially acknowledged superior groups.

This structured approach to management was in keeping with the principles of scientific management, which was a task-orientated philosophy and one which clearly separated the supervisor from the worker (Harmon & Mayer 1986). This prescriptive style was further reinforced by the bureaucratic style of management introduced by Weber at the beginning of this century (Harmon & Mayer 1986). The influence of these management philosophies over nursing practice have persisted for all of the 20th century and are still evident in the hierarchical structure which describes the organization of nursing (Salvage 1985).

This pyramidal organization of nurses (see Fig. 1) clearly shows the relationship of the nurse executive to the nursing workforce which has been classed into three major categories: nurse managers; professional nurses and generalist nurses located at the base of the pyramid (White 1984). The separation of the nurse executive from the mainstream nursing workforce is now raising questions about the relevance of this particular role to nursing and nurses.

The changing face of health care should be viewed by nurse executives as a series of opportunities for trans-

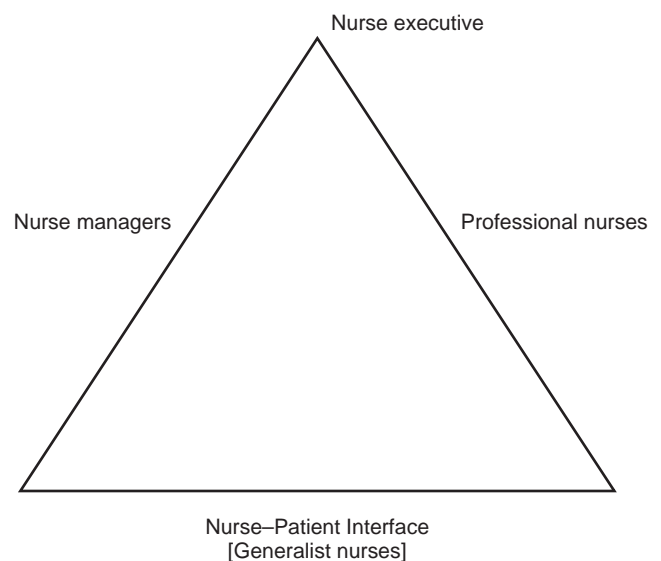


Figure 1
The hierarchical organization of nursing.

forming health agency cultures from a disease orientation to one focusing on wellness (McDonagh 1998). The old competencies required of a nurse executive are no longer appropriate for a constantly changing environment driven by competing demands. The nurse executive has to coalesce the technical demands of management with the visionary dimensions of leadership if nursing is to survive into the next century as a discrete entity. The management/leadership comparison (see Table 1) also provides a conceptualization of the competencies required by the nurse executive of the 21st century.

Embracing a leadership philosophy and mode of operation will require the nurse executive to demonstrate optimism, persistence and courage (Jobes & Steinbader 1996). Of these three qualities, courage is perhaps the most important. The nurse executive will need courage to overcome the constraints and influences of history and

gender socialization to ensure that health services delivery is not compromised, nor nurses disadvantaged within an increasingly turbulent environment which continues to discount what nurses do (Ashley 1976).

Changing the role of the nurse executive

The dynamic nature of the health care system requires that the role of the nurse executive be redefined for the role to remain viable and to ensure that nursing concerns are still brought to the decision- and policy-making tables (Alexander 1997). The old, directive style of management, with its attendant issues of horizontal violence and divisiveness in nursing has to be relegated to the pages of history.

The new role of the nurse executive will be based on the philosophies which underpin the concept of a learning organization which also espouses as an objective, the empowerment of both staff and consumers (Senge 1990). The challenge for the nurse executive is to make the transition from a controlling and directive form of management, to the creation of an environment of organizational transparency, which both recognizes and values all individuals. The disestablishment of health care agencies, and the development of networked health care systems, relocates the nurse executive in what Shortell *et al.* (1993a, p. 20), have termed the holographic organization; this is similar to Handy's (1995) concept of the virtual organization.

The new, vertically integrated model of health services delivery requires that the core business of a health system be redefined to reflect a new model of care where the focus is not on inpatient care, but rather 'a wellness-orientated primary care' (Shortell *et al.* 1993a, p. 24). In the new model, the nurse executive has the opportunity to assume an integrative function in health services delivery, using the tools of integration model as described by Shortell *et al.* (1993b) and reproduced in Fig. 2.

Figure 2 facilitates taking a strategic view of the health care system, focusing on system-wide requirements and including a population-based health needs assessment. Working from the model in a clockwise manner, enables the nurse executive to plan services over a longer-term planning horizon, for example, 5 years. The integrative character of the model recognizes the inter-relatedness of each parameter to maintaining health services delivery coherence.

Distancing, separateness and trust

In a vertically integrated health care environment, distancing and separateness between the nurse executive and the

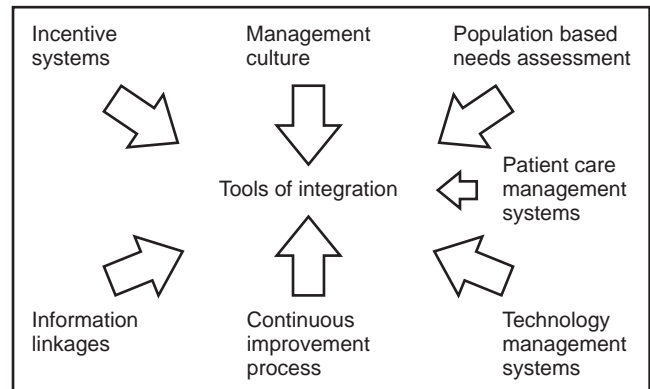


Figure 2
Tools of integration model from Shortell *et al.* (1993b).

nursing workforce become even more pronounced. Distancing has been defined as physical separation, whilst separateness is a symbolic separation. In the past, the nurse executive was separated from the mainstream workforce by both her/his location and by the symbolism attributed to a patient-free nursing role (Humm 1994).

In a vertically integrated health care system, these separations are emphasized even further as the client/consumer moves through stations of health services delivery. The nurse executive can no longer assume a monitoring, controlling and supervisory role over care givers, because of the location variability of service delivery in the networked health care system. To ensure a system-wide, continuous, improvement ethos in service delivery, the nurse executive has to create an environment of trust; trust which is multidirectional and systemic. In a practice setting, where trust underpins all aspects of service delivery, the phenomenon of horizontal violence is absented from individuals' frames of reference.

Trust between individuals at all levels of this new health care organization becomes paramount, as personal, face-to-face communications become the exception rather than the norm. Trust, therefore, becomes a significant factor in determining organizational effectiveness, especially in those hierarchical structures made obsolete by the information technology revolution (Handy 1995).

In the new health care organization of the 21st century, the quality of personal communication, therefore, becomes even more important in the development of a shared commitment and vision for the organization. This requires the nurse executive to synthesize the demands of 'high tech with high touch' (Handy 1995, p. 48).

The challenge for nurse education in the 21st century

Nurse education in the 21st century will be a coalescence of technology and humanism (McConnell 1998). Nurses

Table 2

Leadership competencies profile for the nurse executive in the 21st century.

ESTABLISHING DIRECTIONS Commercial Sensitivity Creativity and Innovation.

Strategic Planning Communication *Demonstrates financial management skills; is able to recognize commercial opportunities as they present and using financial principles translate them into service targets.* Creates and introduces innovative approaches to service delivery; is prepared to question and move beyond traditional models of practice* Develops a vision for the future, usually has a long-term planning horizon. Develops strategies for achieving vision.* Skilled verbal and written communicator, is able to use a variety of media to disseminate

Establishing directions	Commercial sensitivity	*Demonstrates financial management skills; is able to recognize commercial opportunities as they present and using service targets.
	Creativity and innovation	*Creates and introduces innovative approaches to service delivery; is prepared to question and move beyond traditional models of practice
	Strategic planning	*Develops a vision for the future, usually has a long-term planning horizon. Developed strategies for achieving vision.
	Communication	*Skilled verbal and written communicator is able to use a variety of media to disseminate information to multiple professionals and lay audiences.
Aligning people	Enabling role	*Creates an environment which fosters trust, continuous learning and continuous improvement in service delivery.
	Coalescing role	*Coalesces the technological and human dimensions of health services delivery.
	Motivating role	*Motivates individuals to achieve, to overcome structural barriers to empowerment (political, social and historical).
Personal qualities	Flexibility and resilience	*Is able to adapt to a dynamic environment; assumes advocacy role.
	Courage	*Challenges established order where this is contrary to goal achievement and/or service ideals
	Commitment	*Demonstrates commitment to service and organizational goals.
	Inter-personal sensitivity	*Interacts with others sensitively, respectfully and with cultural awareness.

will have to be prepared to work across the integrated system and not just in the hospital settings. The increasing technologization of health care will require a small cadre of professionally prepared nurses to work in health care agencies, however, as lengths of stay reduce, the majority of professional nurses will be located in the networked health care system.

Nurses will become adept technicians, more so than they are now. Technology may be used not only in the direct delivery of nursing care but also indirectly, in the shape of telenursing. Telenursing has the potential to reconfigure current community-based nursing practice.

The education of nurses must move beyond the traditional biomedical teachings. If nurses are to take their rightful place in the new health care system, then nurses must be prepared to work in a virtual organization,

blending technology, and the humanistic dimensions that influence the health of a population (McConnell 1998).

The nurse executive has the responsibility for creating a work environment supported by trust which synthesizes technological and humanistic health care delivery and promotes competence. Effectiveness in the nurse executive role also requires a balance between technological competence and human endeavour in the exchanges between administrative and practitioner staff. Competencies in practice, and this applies equally to the nurse executive, are maintained in environments where continuous learning is a cornerstone of organizational culture.

Competencies for the nurse executive extend beyond demonstrations of managerial ability into the domain of leadership. As a leader within a health care system, the nurse executive continually looks for windows of

opportunity which will enhance the shared strategic vision. Rambur (1998), sees a window of opportunity for nurses resulting from the erosion of the physician's role by managerialism; however, this requires an unbundling of old skills and behaviours if the nurse executive is to assume leadership/advocacy role in health, not just nursing.

The nurse executive will also require superior skills in all aspects of communication, so as to disseminate information throughout the organization with accuracy and timeliness. Coalescing and making coherent the varied and disparate activities carried out in a boundless organization will raise the nurse executive's co-ordinating skills beyond managerial competence. A competency profile for the nurse executive of the 21st century is presented in Table 2.

Although Table 2 is by no means exhaustive, it does reflect the competencies required for demonstrations of leadership by a nurse executive working in a health care organization of the future.

Conclusion

The health care organization of the future will bear little resemblance to the models of institutional health care available today. There is growing evidence to indicate that the future of health services delivery will be described within vertically integrated systems 'embracing primary care, wellness, home health, long-term health, and related components of the health continuum' (Shortell *et al.* 1993b, p. 47). The changes to service delivery will result in windows of opportunity for nursing to take a lead role in the redefinition of health care in the next century (Gilmartin 1998; McDonagh 1998; Rambur 1998).

However, for this to occur, current nurse leaders will have to move away from traditional managerial practices and behaviours in order to assume a leadership role in health care. The changes which are occurring in health care systems offer nurses opportunities to become key players in setting future health care policy direction, all it requires is courage.

References

- Alexander C.C. (1997) The nurse executive in the 21st century: how do we prepare? *Nursing Administration Quarterly* 22 (1), 76–82.
- Ashley J.A. (1976) *Hospitals, Paternalism and the Nurse*. Teachers College Press, Teachers College, Columbia University, New York, NY.
- Australian Nursing Federation (1998) Hanson under fire over nursing plans. *ANF Journal* 6 (1), July, 12.
- Badaraccho J.L. (1998) *The Discipline of Building Character*. Harvard Business Review on Leadership. Harvard Business School Press, Cambridge, MA, 89–114.
- Bayly M.E. (1987) The Nightingale nurses: the myth and the reality. In *Nursing history: the state of the art*, (ed. C. Maggs), Cream Helm, London, 35–39.
- Borman J. & Biordi D. (1992) Female nurse executives, finally at an advantage? *Journal of Nursing Administration* 22(9), September: 37–41.
- Clay T. (1987) *Political Issues in Nursing*. Heinemann, London.
- Condon E.H. (1991) Nursing and the caring metaphor: gender and political influences on an ethics of care. In *Critique, Resistance and Action*, Working Papers on the Politics of Nursing (eds J.L. Thompson, D.G. Allen & L. Rodrigues-Fisher), National League for Nursing Press, New York, NY, 69–83.
- Dingwall R., Rafferty A.M. & Webster C. (1988) *An Introduction to the Social History of Nursing*. Routledge, London.
- Duffield C. (1994) Nursing unit managers: defining a role. *Nursing Management* 25 (4), 63–67.
- Evans J. (1997) Men in nursing: issues of gender segregation and hidden advantage. *Journal of Advanced Nursing* 26, 226–231.
- Fatchett A. (1994) *Politics, Policy and Nursing*. Baillere-Tindall, London.
- Forsyth S. (1995) Historical continuities and constraints in the professionalism of nursing. *Nursing Inquiry* 2, 164–171.
- Game A. & Pringle R. (1983) *Gender at Work*. Allen & Unwin, Sydney, Australia.
- Gardner H. & McCoppin B. (1989) Emerging militancy? The politicisation of Australian allied health professionals. In *The Australian Experience The Politics of Health* (ed. H. Gardner), Churchill Livingstone, Melbourne, 303–348.
- Godden J. (1995) Victorian influences on the development of nursing. In *Scholarship in the Discipline of Nursing* (eds G. Gray & R. Pratt), Churchill Livingstone, Melbourne, 243–258.
- Gilmartin M. (1998) The nursing organization and the transformation of health care for the 21st century, (entrepreneurship: shifting paradigms). *Nursing Administration Quarterly* 22, 70–87.
- Greenwood A. (1997) Leadership for change. *Nursing Standard* 11 (19), 22–23.
- Halsey S. (1978) The queen bee syndrome: one solution to role conflict for nurse managers. In *Role Theory Perspectives for Health Professionals* (eds M.E. Hardy & M.E. Conway), Appleton-Century Crofts, East Norwalk, CT.
- Harmon M. & Mayer R.T. (1986) *Organization Theory for Public Administration*. Little Brown & Company, Boston, MA.
- Handy C. (1995) Trust and the virtual organization. *Harvard Business Review*, May–June, 40–50.
- Harrison S. & Pollitt C. (1995) *Controlling Health Professionals*. Open University Press, Buckingham.
- Henderson M.C. (1995) Nurse executives, leadership motivation and leadership effectiveness. *Journal of Nursing Administration* 25 (4), April, 45–51.
- Hockley C. (1990) *Social Characteristics Profile of a CEO with a Nursing Background*. Masters Thesis, The Faculty of Education, The University of New England, Armidale.
- Humm C. (1994) Who's boss now? *Nursing Standard* 9 (11), 44.
- Irurita V. (1990) *Optimising as a Leadership Process: a Grounded Theory Study of Nurse Leaders in Western Australia*. PhD Thesis, University of Western Australia.
- Jobs M. & Steinbader A. (1996) Transitions in nursing leadership roles. *Nursing Administration Quarterly* 20 (2), 80–84.

- Johnstone M.-J. (1994) *Nursing and the Injustices of the Law*. Harcourt Brace, Sydney.
- Kotter (1994) Leadership. Fortune Magazine Video Seminars a Nathan Tyler Production. Harrard Business School, Boston, MA.
- McDonagh K.J. (1998) The nurse as senior health care executive, (entrepreneurship: shifting paradigms), *Nursing Administration Quarterly* 22, 22–30.
- McConnell E. (1998) The coalescence of technology and humanism in nursing practice: it doesn't just happen and doesn't come easily. *Holistic Nursing Practice*, www.elibrary.com/getdoc.cgi?id=119.
- Muff J. (1988) Of images and ideals. A look at socialization and sexism in nursing. In *The Image of the Nurse* (ed. A.H. Jones), The University of Pennsylvania Press, Pittsburgh, PA, 197–220.
- Muller H.J. & Cocotas C. (1988) Women in power: new leadership in the health industry. *Health Care for Women International* 9, 63–82.
- Owens P. & Glennerster H. (1990) *Nursing in Conflict*. MacMillan, London.
- Palmer G. & Short S.D. (1989) *Health Care and Public Policy. An Australian Analysis*. MacMillan, Melbourne.
- Peterson V.S. (1993) Disciplining practiced/practices; gendered states and politics. In *Knowledges, historical and critical studies in disciplinarity*, (ed. E. Messer-Davidow, D.R. Shumway, D.R. Sylvan), University Press of Virginia, Charlottesville, Virginia, VA, 243.
- Rambur B. (1998) Ethics, economics and the erosion of physician authority: a leadership role for nurses. *Advances in Nursing Science* 20 (4), 62–71.
- Roberts S.J. (1997) Nurse executives in the 1990s: empowered or oppressed? *Nursing Administration Quarterly* 22, 64–72.
- Salvage J. (1985) *The Politics of Nursing*. Butterworth-Heinemann Ltd, Oxford.
- Senge P. (1990) The leader's new work: building learning organizations. *Sloan Management Review*, Autumn, 9–23.
- Shortell S.M., Anderson D.A., Gillies R.R., Mitchell J.B. & Morgan K.L. (1993a) The holographic organization. *Healthcare Forum Journal*, March/April, 20–26.
- Shortell S.M., Gillies R.R., Anderson D.A., Mitchell J.B. & Morgan K.L. (1993b) Creating organized delivery systems: the barriers and the facilitators. *Hospital and Health Services Administration* 38 (4), 447–466.
- Still L., Guerin C.D. & Chia W. (1992) *Women in Management Revisited: Progress, Regression or Status Quo?* Women in Management Series, Paper no. 18. Faculty of Commerce, University of Western Sydney, Nepean.
- Strauss A. (1966) The structure and ideology of American nursing: an interpretation. In *The nursing profession: five sociological essays*, (ed. F. Davis), John Wiley & Sons, New York, NY, 60–107.
- White R. (1984) Nursing: past trends, future policies. *Journal of Advanced Nursing* 9, 555–562.