Nursing Praxis in New Zealand

PERCEPTIONS OF POLICY AND POLITICAL LEADERSHIP IN NURSING IN NEW ZEALAND.

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Abstract

This qualitative study was focused on the landscape of nursing policy and political leadership in New Zealand. A volunteer sample (N=18) of nurse leaders (Fellows of the College of Nurses Aotearoa (NZ) Inc) drawn from across the country was interviewed with respect to issues that affect their interest in participating in political action and policy work. The framework of stages of nursing’s political development published by Cohen and colleagues (1996) was used as an interview guide. Respondents were asked to describe their own stage of political development, their perception of the political development of New Zealand nurses and nursing organisations at large, and also their thoughts on what could be done to better position nursing in healthcare policy development. In general, respondents agreed that the major nursing organisations in New Zealand (the College of Nurses – Aotearoa and New Zealand Nurses Organisation [NZNO]) were moving toward increasing policy sophistication. Qualitative content analysis suggested five themes which, taken together, describe nursing’s policy/political development in New Zealand: languaging; succession /legacy planning; Tall Poppies and Queen Bees; “it’s a small country”; and speaking with one voice. Although limited by sample size, the information collected provides a beginning focus for discussion that can steer New Zealand nursing activities toward the wider involvement of nurse leaders in healthcare policy work on behalf of the discipline.

Key words: Nursing leadership; policy and politics; nursing organisations; qualitative study; New Zealand nursing

Introduction

It is most common to think of leadership in nursing as positional leadership: individuals who take the helm of health sector institutions, professional organisations and nursing teams. There is, however, equally vital leadership required of those nurses who take the nursing disciplinary perspective into decision making fora within nursing itself and in the wider health policy environment. This paper considers “leadership” in the broadest sense. Nursing leadership may develop first in positions at the most local level, and then may evolve in sophistication, range and scope. In New Zealand, as in the US (Institute of Medicine, 2010) and the U.K (Front Line Care, 2010) there seems to be a gap in the discipline of nursing between emerging leadership by position and that which is required for the discipline to sit comfortably at policy tables. We use “discipline” rather than “profession” to connote “a branch of learning or scholarly instruction” rather than a vocation (as cited in Brown [Ed], 2002, p.693 [discipline], p. 2358 [profession]). For purposes of this study, politics is the art and acts of persuasion and policy is the set of values behind acts of government.

New Zealand has undergone major changes in the healthcare system over the last 25 years. This included what could have been described as a deconstruction of the nursing workforce. The relationship between the government and its departments was redesigned leaving the healthcare system (including the nurse at the bedside) unclear not only about who was responsible for decision making, but also who was accountable for performance and outcomes (Hughes & Carreyer, 2011). One of the most radical changes within the government structure that affected New Zealand nursing involved the State Sector Act 1988. This Act in effect eliminated the nursing division that existed in the Department of Health and reconfigured, by minimizing, nursing representation at the national level. At that time the Department of Health was renamed as the Ministry of Health. Continued restructuring occurred until 1993.

The health reforms of the 1990s affected hospital operations, especially nursing. Nurse managers at the nursing ward level and above were eliminated in favor of generic managers who could be selected from any industry (Buchan & North, 2008), and previously discipline-specific budgets were centralized. During the 1990s there was increased substitution of registered nurses (RNs) by unlicensed personnel. Length of hospital stay decreased, workloads increased and senior nurses and new graduates began to leave the country (Carreyer, Diers, McCloskey & Wilson, 2010). New Zealand essentially lost two generations of nursing leadership in the reforms.

Purpose

The purpose of this study was to examine present perceptions of policy and political leadership in nursing in New Zealand. The study was undertaken with the sponsorship of The College of Nurses – Aotearoa.

Methods

The research was designed as a qualitative, descriptive study addressing the question of what perceptions of New Zealand nurse leaders have of nursing’s policy and political development in the country?

The study was granted expedited approval by the Human Research Committee of Yale University, USA. Interviews were conducted using the framework published by Cohen and colleagues (1996). Cohen stages nursing’s political development and sophistication by summarizing key components into four stages (Table 1), each with four components. As nursing’s policy and political development grows, nursing’s language, affiliations and activities turn from a concentration on internal nursing issues to a view leading to societal and health service delivery changes. (Cohen et al., 1996)

Respondents were Fellows of the College of Nurses Aotearoa (NZ) Inc who volunteered through a standard solicitation of the College. At the time, there were 95 Fellows. Fellows of the College were, by definition and membership criteria, “leaders”. Many hold membership in other New Zealand nursing leadership organisations including NZNO. In the limited time available for data collection, it was efficient to use the College’s resources to solicit interest and arrange interviews. Interviews were scheduled by a staff administrative assistant at the College. Participants remained anonymous to the College and neither their identity nor transcripts of interviews were shared with the College leadership. All but two of the interviews were conducted in person in a private location chosen by the participants; the remaining two interviews were conducted by telephone.

The stages of nursing’s political development described by Cohen and colleagues (Cohen, Mason, Kovner et al.,
1996) guided the study. A brief explanation of Cohen’s framework was given prior to beginning the interview and opportunities for questions and clarification were afforded to the participants. Participants were handed a laminated version of the table (Table 1) to refer to during the interview and asked to determine their own stage of political development and their perception of the political development of New Zealand nurses at large. The table was provided via email for the participants for whom the interviews were conducted by phone. All interviews were digitally recorded and information was downloaded onto a secure laptop. Signed informed consent was obtained. Respondents were assured that their names would not be used and no personally identifiable data were collected. Respondents could terminate the interview at any time and all content to that point would be erased. No one requested this action. A commercial transcribing service was used. Only the researcher and the external reader (Prof. Diers) saw the transcripts. Constant comparative analysis techniques were used to analyse the interview results. The transcripts were read and re read multiple times to identify concepts which were then organised by color coding concepts in the transcripts. The external reader verified the concepts that emerged, and discussion with the external reader developed these concepts into themes for analysis.

Participants

All Fellows (N=95) were contacted; a total of 25 respondents volunteered in a timely fashion for the interviews. They were located throughout New Zealand (on both main islands) and were from both rural and urban areas. Eighteen (18) interviews were scheduled based on availability of both the participants and the interviewer. A brief demographic form was used to collect information to describe the sample. The age range of respondents was 49 to 65 years; 65% were Masters prepared and 35% were prepared at the Doctoral level. Nearly all (93%) began their nursing education in a hospital based program. The mean length of membership in the College was 9.87 years. The major membership organisations in New Zealand referred to in the interviews were the New Zealand Nurses Organisation (NZNO) the College of Nurses Aotearoa (NZ) Inc and Te Ao Maramatanga, The College of Mental Health Nurses.

New Zealand Nursing’s Policy/Political Development

Those interviewed were very enthusiastic; the questions were well received and the dialogue was rich with strong opinions. There was considerable agreement among those interviewed that of the nursing organisations involved in policy work in New Zealand, the College of Nurses generally fell between stage 3 (Political sophistication) and stage 4 (Leading the way) and, the NZNO generally fell between stage 2 (Self interest) and stage 3 (Political sophistication) but there was a range of judgments.

In the following sections, quotations from the interview transcripts have been selected to portray the range of nuance.

The College sort of fits in 3 and 4 and that’s a strong group of nurses whose names we hear all the time and who publish a lot and who are influential in making submissions to the Ministry of Health and to the government and they’re definitely leaders. (Respondent 10)

I think they [the College] try to be in stage 3 and 4 because most of the issues, they have the freedom of being able to actually deal with those sort of issues, they don’t you know, like the NZNO has to respond to what’s happening to nurses you know on a day to day basis...the College has the liberty of being able to actually be a bit more proactive. (Respondent 17)
I think over probably the last couple of years, they’ve [NZNO] moved far more into the stage 3... it’s a huge group of nurses of which you have got some very proactive people in there as well as some really good people who are working hard for nursing. You’ve also got a large cohort of people who are, in fact, reactive, so stage 2 probably. (Respondent 11)

I would say [NZNO] would be between 2 and 3, but it’s generally leading the way too. I think the understanding of the College is that we all have an expectation to contribute. (Respondent 12)

These perceptions are not particularly surprising given the distinct agendas of the two organisations. The framework used for these interviews is a policy framework. Since the mission of the College is primarily to address policy and the mission of NZNO includes that of industrial relations, the perceptions of the respondents reflect this difference. That both organisations are perceived to be at the higher end of the scale is a considerable achievement that many countries would envy.

Themes

There were five consistent themes that emerged throughout the interviews: the importance of the understanding of language in order to promote nursing’s agenda; succession planning; Tall Poppies/Queen Bees; “it’s a small country”; and speaking with one voice.

Languaging

The use of language is the first element in Cohen’s framework and thus was often the focus of respondents’ initial thoughts. The importance of understanding how and what type of language is being used by nursing was evident throughout the interviews. This theme generally speaks to the need for nurses to begin to learn the language of politics and to be able to effectively message their needs in a way that political leaders, the media and the public will find understandable and credible.

Well, I think we have to kind of learn the language in order to communicate with those people. But then I think we need to stay true to our own philosophies. So, if you like, we’re using their language to get to our ends. ...That’s our insider language. And that’s using the language of the dominant group, if you like; in order to make this [nursing] come alive, make it visible. (Respondent 10)

I’m sure that most people would say that we’re using a lot of nursing jargon and do we actually know what those words mean or do we have a common shared understanding of those words? (Respondent 7)

These responses reflect the internal quandary many nurses feel about leaving their natural shorthand ways of communicating to adopt the foreign language of others outside the discipline. The multiple and conflicting requirements to communicate clearly, to educate those outside the discipline, to fully represent nursing’s aspirations and issues but not to sell out to the perspectives of others to the detriment of the discipline may be psychologically difficult for nursing. These multiple demands were seen as being embodied by one particular leader when a participant said:

She is a nurse but she can keep up the dialogue about tertiary education and education reform and health outcomes and so on, so she is on the same level as us. So therefore she’s not dumb and if she’s not dumb perhaps they’re all not dumb. (Respondent 4)

This respondent seems to be saying when one nurse is able to operate on the policy level using policy language; it confers some degree of credibility onto the rest of nurses. Some respondents suggested shifting the nursing language paradigms:
I think we have got, we really have to learn to stop talking about nursing and start talking about healthy outcomes because I think that's one of the most powerful things we can do. (Respondent 4)

The more research we do, the more we believe in ourselves, the more knowledge that is produced and when you speak from research you're speaking from evidence rather than self...I think that is more powerful. (Respondent 12)

And we have to take some responsibility for that because as nurses we need to find the language and the way to connect...because at the end of the day you have to talk the language that's gonna be understood. So what's the financial cost? What's the data that says if we don't have a nurse this is what happens? (Respondent 8)

These comments reflect the recognition that, whether we like it or not, the world of policy and politics responds to quantitative results. That does not have to mean, however, that narrative does not matter. Indeed, the role of narrative, of anecdote, of nursing observation is increasingly being recognized as effective in getting policy attention. Once the attention is gained, however, different strategies may be in order. Although the theme of language might have been prompted by the Table used for the interview, respondents realized that while nurses need not change the language they are using, they must be able to associate their language with the issue on the policy table.

One respondent pointed to “leading the way”:

You know if anyone should be speaking out for the poor, for the disaffected, for the sick, for families and things it should be nurses, but you don't hear it. (Respondent 17)

Although it is not reflected in the comments just cited the College’s website is full of activities related to social justice and NZNO has been particularly active in these spheres in the last five years. That this respondent does not feel these issues are being addressed adequately may reflect that her/his individual interest is not reflected in the current body of work of the organisations. Alternatively it may mean that this respondent does not fully engage with what is available.

Succession planning/legacy planning

Many of the interview participants were concerned with succession planning/legacy planning within nursing in New Zealand. Many felt that there has not been a clear or structured effort to move younger, less experienced leaders into the leadership inner circle. While the concern was evident, solutions were not as obvious to the participants. Time and resource constraints were some of the primary reasons for the existing gap.

I am not sure I see it happening [succession planning]... but I see people that have been in leadership or so-called leadership positions for numerous years and I don't see succession planning to, you know, encourage others to move up. (Respondent 12)

Well, I probably don't do it very well [succession planning] and that is one of our challenges because if you have a model that's invested in personalities and knowledge of- like if [name] stepped down from [organisation] for example, there would be a gap because she has...become the embodiment of the group and that's not helpful in terms of succession planning. (Respondent 8)

It's one of their biggest weaknesses [succession planning], they [the College] have to get more people actually who, more spokespeople, some of the leaders that are actually there stepping back and actually let others do the work. (Respondent 17)
So I don’t think people really understand how important succession planning is and how much influence the young could have if we could get them on board. (Respondent 4)

While there is a perception that the leadership options are already taken and closed, it will be difficult both for the leaders to find potential successors and for the potential successors to believe they have a chance at leadership. One of the most difficult jobs an organisation has is in managing succession or leadership change. But it must be done if the life of the organisation and its agenda for policy change is to be preserved. There was a consistent perception that leadership develops almost accidentally. Several of the respondents said some version of, “I never really planned it [to be a leader]. It kind of just happened.”

I think, joking aside, the mentors that I’ve had, have been really influential in shaping who I am as a leader. I just stumbled on mine but I know people sometimes do seek out mentors. And I think that as leaders ourselves, it’s our responsibilities to mentor others definitely. But there’s no formal process. It’s more serendipity. (Respondent 8)

Two respondents suggested a possible direction in talent management:

I come from the ‘70’s. As a small child, I thought the beatniks were great... We were formed on the basis of carrying a placard and having a cause...I think especially looking at the really younger nurses now, the Gen Y’s who are coming in; they have a very different outlook on life. So they choose not to go rather than to try to change it. We didn’t know anything but to try to change it. (Respondent 4)

We were the ‘60’s, you see, the 60’s was normally a very active generation. And so, you know, not just in nursing. There was also amazing change going on outside of nursing. It was a very exciting sort of dynamic change. And so you had a whole different approach to things. ...I was involved in a quite a lot of political action and social justice issues outside of nursing. So I guess it’s, for me, it’s a part of my life. (Respondent 9)

These responses suggest that leadership only takes hold when you are willing to work toward change or believe in a cause. There is an untested assumption here, however, that the younger generation does not think the same way. In the ‘60’s, if the way was blocked, the solution was challenge or protest. Now, if the way is blocked, there is the feeling that the younger generation will just find a different way around but not confront directly and honestly and thus not show “leadership.” There may even be an assumption that the younger ones are simply too much concerned for themselves to wish to engage in the hurly burly of leadership.

Succession planning is never easy. In healthcare especially, people are so busy trying to survive in a complex environment that investing energy in mentoring or supporting the development of those coming up behind is difficult even if the necessity is obvious. Succession planning, then, is both allowing space for new leadership to emerge and developing or mentoring new talent. Neither can be left to chance.

Tall poppies and Queen bees

These metaphors for leadership behaviors emerged several times during the interviews. Recognizing the difference between them, however, they were combined as a single theme because they represent perceptions of leadership. Tall Poppy Syndrome is defined as a tendency to discredit or disparage any person who has achieved success in public life (the usage noted to be “now chiefly Australian”) (tall poppy [p 2285] in Brown, 2002). Queen Bee syndrome has been defined as individuals who gained their power by
aligning with male power or with the dominant group alongside their own positional group (in nursing's case, medicine) and used specific anti-feminist tendencies to stop the progression of other females (Klemensrud, 1981). It has also been used to describe a woman who has succeeded in her career and who refuses to help other women do the same.

I think the College is seen as being the Tall Poppy and NZNO is looking after the rest. (Respondent 10)

So I think there's a part of it that's gendered and partly cultural for New Zealand. And I say that because in some countries I see that people are... to be political is to be, you know, you're admired for being political. But that's not so in New Zealand on the whole. That's starting to change but there's a big sort of Tall Poppy Syndrome thing that goes on here. (Respondent 17)

These comments align with the Tall Poppy definition in the literature. But another respondent put a different twist to it:

There's a big sort of Tall Poppy syndrome thing that goes on here. If you put your head up and grow above other people you'll get the top chopped off basically. So stay within the group, don't grow outside of that otherwise people will, you know, chop your head off. (Respondent 7)

Whichever twist of definition is taken to Tall Poppies, the connotation is negative.

...I'm thinking of another thing we do have, what we would call the Queen Bee syndrome. That's where a nurse gets to a position of power and then anyone who starts coming up who looks like they might be perhaps threatening their position of power, [she] stings, stings you as you come up. (Respondent 19)

Both of these syndromes suggest that leadership is negative, or not to be aspired to for the danger in succumbing to the Tall Poppy or Queen Bee syndrome. Tall Poppies or Queen Bees are negative metaphors when it would be equally possible to see Tall Poppies as leaders channeling the sun, and Queen Bees as nourishing the hive. The historical hierarchical notion of leadership is still alive and well, while notions of collegial or representational or other more contemporary notions of leadership have yet to emerge. This is not a problem specific to New Zealand as most of the world has seen hierarchies whose authority was responsible for great evil. Yet conventional wisdom has it that progress will only be achieved with the kind of leadership that produces Queen Bees and Tall Poppies. Feminist theories have not penetrated far into leadership development or practice. What is absent from the perceptions above is a strong sense of personal determination or power of change. That all of the nurses were Fellows of a leadership organisation makes this absence even more striking.

"It's a small country"

New Zealand is a small country in population although large in geography. Respondents were often very aware of the effect the small population (of nurses or nurse leaders) might have in policy and political development. It's tricky in New Zealand, you see, because the workforce is quite compared to somewhere like the States or even Australia. But that means the number of senior nursing positions is quite small as well. I do think we've got to think of some way of creating a space for those nurses to find out what they want...the next generation of nurses, to find out what they want to do in terms of leadership. (Respondent 5)

This comment reflects the traditional notion that leadership is positional rather than a process. You go to any national nursing meeting and it's like,
'Oh hello.' Because we are a very small country...so there's probably only about 20 or 30 nurses that are working in this way and so it's easy to know them. (Respondent 8)

New Zealand's quite a small country as far as that goes. In fact, just getting on a plane the other day, not that I'm important, but you start thinking you know half the plane. (Respondent 18)

These comments might suggest that the fact that there are a small number of defined positional leaders is a disadvantage. Perhaps there is the hint that knowing each other so well means working together is predictable and immutable. This is an assumption which might be tested.

You have to be really careful in a small country that personalities and those sort of things don't get in the way and so you have to actively work to make sure that it doesn't happen. Because otherwise you can get into a situation where people bring a lot of baggage to decisions and political alliances and that's not always good. (Respondent 5)

Other respondents saw virtue in being small:

So even if you go to Australia ... the change in New Zealand, because it's quite small, is really rapid. (Respondent 5)

Recently there's been a lot of coalition forming among the nursing groups and they're putting out consensus documents and consensus statements. We're very linked and because New Zealand is so small, it's different from a lot of other countries. So we're very linked into whatever is going on in government policy generally. (Respondent 5)

The responses convey a recognition that although there may be some challenges to a small country there are distinct advantages: change can take place both rapidly and efficiently; relationships are formed easily because of the smaller numbers; relationships can be maintained more readily because of the size of the group and geography; and relationships between nurse leaders and policy makers can be fostered to a quite familiar and advantageous level. Yet:

Because we are such a small country many people fit in more than one camp so some people live in quite conflicted situations. (Respondent 4)

Speaking with one voice

Nurses in many countries may have difficulties in the policy arena because politicians or bureaucrats do not understand the reason why nursing has so many "voices" – some of them all too publically in conflict. Respondents recognized this problem, including some of the subtleties of intra-professional debate and cooperation.

And the nurses’ union and the College have always had differences of view but they were smart enough, in my view, to put those aside while they were becoming a joint force and they spoke with one voice in the media...and that was good. (Respondent 6)

I think people have just realized that, particularly in New Zealand, one of the things that we’ve been accused of, over the last couple of years, by health leaders saying ‘Don’t listen to nurses, because they can’t speak with one voice, so they’re always squabbling about things. (Respondent 11)

Now nursing voices should be unified around particular issues....we should say ‘as nurses this is what we believe people should have when they need our services’ so in that respect, yeah, I think it’s really important. (Respondent 9)

Respondents recognized that in a small country, and in a discipline as complex as nursing, there need to be differing agendas and differing voices. But when it is necessary to be at the policy table with a unified message, nursing needs mechanisms to bring issues forward as one voice for the discipline. Respondents recognized the significant progress of the nursing organisations in the country in working together to advance the discipline.
It is also recognized that it is in the interest of others (government, external agencies) to portray nursing as divided, and some nurses may also believe this. This portrayal imposes a perception of disorganisation around a cause and can diminish nursing's credibility not only on the particular issue, but in general. It feeds a trite picture of nurses as women squabbling and unable to rise about genuine differences. But this is not nursing's problem, it is a tactic sometimes employed to keep nursing at a policy distance.

Discussion

The respondents were excited to talk about these issues. They were generous of their time and thoughts and they wanted to engage in a real discussion. The interviews are rich in detail and only partially reported here. The interviewer was particularly struck by the depth of their knowledge, and the ways in which respondents closed the social distance between themselves and her - an American graduate student. Respondents were generally humble about their own place in the Cohen framework of political development, and how they came to be where they were. Most rated themselves in category 3 in the framework, noting that there were others "leading the way." But the respondents held a wide variety of senior leadership positions, so their self-ratings may be a combination of humility and recognition of how much more there is to be done.

There was a surprising amount of agreement which made uncovering the themes straightforward. This may have been an effect of having in a small country, a volunteer sample of Fellows in an organisation whose mission includes speaking for the discipline. Taken together, the themes identified here provide a picture of nurses in New Zealand understanding that new ways of speaking might be necessary for full participation at policy levels, but not being quite certain how to learn that new language without giving up nursing's special and colourful service vocabulary. There was a genuine sense, even anxiety, about the need to develop successors to those known in this small country to hold the public leadership positions, yet respondents did not seem to know how to proceed, and appeared to want the national leaders themselves to do the succession planning.

Positional leadership is just one way to think about moving agendas forward. Leadership is also (and more) a process which can be identified, publicized even when it is not done by defined leaders. Respondents suggested that the Tall Poppy/Queen Bee phenomena might frighten people away from leadership opportunities, but they did not seem to question how these phenomena come to be so perceived, nor how to portray leadership so that it does not invoke these negative stereotypes.

There was some considerable agreement that nurses in New Zealand have made major strides toward working together and speaking with one voice. Perhaps in a small country, it is more difficult than it would be in a larger one, to see over the horizon and appreciate the enormous progress nursing in New Zealand has made from its nadir in the early 1990's to the present. It is too easy to equate "small" with "insignificant" when in fact New Zealand was the first country to have a Chief Nurse position in government (Hughes, 2002a,b), was probably first to convert its entire nursing education system to university level, and is taking leadership at this moment in refining "specialty" or "advanced" nursing practice.

What may be idiosyncratic to New Zealand is the relatively flat structure of government. There are no states or counties with governmental structures that might provide training grounds. Healthcare has more levels in DHBs but still the distance between nurses at the bedside and the Minister of Health is, to the USA eye, scarily short. The Minister or his advisor can text
message directly to nursing leaders which requires the nurses on the end of the texting chain to have an acute sense of how to respond at this executive level. This may be intimidating to those who have not done it, but this is a set of skills and understandings that can be taught.

There is, much more to be done, as there always will be. But being a small country is a huge advantage for New Zealand and one upon which new initiatives might be built. The public do not generally think of nurses as leaders nor of the discipline as leading health care delivery. But the majority of nurses in this study rated the discipline in the top two categories of policy/political sophistication. It would be surprising if such high ratings could be achieved in many other countries, certainly it is not so in the United States.

Thus, the time might be ripe for New Zealand nursing, through its major organisations, to craft a strategic plan for development of nursing leadership for the next five years or so. It is a propitious time to “hardwire” into place systematic ways for nurses to begin and develop their leadership skills and activities through some structured mechanisms to support what is already a fairly well developed, if invisible, network of choice and mentoring. Such structures should cover the entire range of places where nurses work and levels of organisations, from “the bedside to the boardroom” as contemporary reviews of nursing leadership are saying (Institute of Medicine, 2010; Front Line Nursing, 2010).

Structures should also cover the variety of ways in which people learn leadership: by doing, by studying, by observing. Examples might include:

- released time from practice or teaching for project-specific work
- study leave (for short or long periods)
- short term workshops with follow up and continued mentoring
- specific papers in bachelor and higher degree programs
- directed reading and discussion ("journal clubs") associated with work or study sites
- internships or similar placements with defined nursing leaders in workplaces, on Boards, in professional organisations, in the media and especially in the Ministry of Health
- creation and maintenance of blogs, websites, chat rooms, Facebook pages or other social media-based opportunities for leadership development;
- publicity about nursing innovations and initiatives
- support for travel to international meetings focused on leadership development

There is a need for focused efforts toward leadership development in nursing especially because as a primarily female discipline, the value system is based in service rather than in power. It will be necessary to translate that service dedication into “leading the way” as a discipline in partnership with others, but it cannot be expected that the translation will happen automatically. There are limitations to how much can change and how quickly.

This study is limited by a small sample, and its qualitative design. Time constrained the number of interviews that could be conducted and the selection of potential interview pools. Data were collected by a U.S. graduate student who may not have fully grasped nuances of New Zealand language.

Implications for future research

A similar study could be conducted in other jurisdictions in developed and developing countries, to see if and how nurses’ perceptions of leadership vary. It would also be interesting to nest nurses’ perceptions in a wider study of how healthcare is delivered in different countries. Where nurses perceive a distance from policy and political involvement, is nursing also less
influential at the level of practice? Finally, studying nurses’ perceptions over time as nurses take on larger policy roles or, as in the U.S. and U.K. healthcare reform opens new possibilities, would track nurses’ policy and political development.

Conclusion

Nursing policy and political development is alive and well in New Zealand. There is a deep pool of enthusiasm and eagerness to contribute to better health and health care. With new initiatives toward collaboration and with a deeper understanding of how nursing leaders perceive this work, it should be possible to concentrate forward movement to take best advantage of this latent energy even in a small country with strained resources.

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