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The Relationship between Leadership/Followership in Staff Nurses and Employment Setting

Elaine S. VanDoren
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THE RELATIONSHIP BETWEEN LEADERSHIP/FOLLOWERSHIP IN STAFF NURSES AND EMPLOYMENT SETTING

by

Elaine S. VanDoren

A Dissertation Submitted to the Faculty of The Graduate College in partial fulfillment of the requirements for the Degree of Doctor of Philosophy Department of Educational Leadership

Western Michigan University
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THE RELATIONSHIP BETWEEN LEADERSHIP/FOLLOWERSHIP IN STAFF NURSES AND EMPLOYMENT SETTING

Elaine S. VanDoren, Ph.D.
Western Michigan University, 1998

This study tested the hypothesis that staff nurses in hospitals used different leadership and followership behaviors than staff nurses in home care settings. Leadership behaviors were measured using the Multifactor Leadership Questionnaire (Bass, 1995); followership was measured using Kelley's Followership Style Questionnaire (1992). Three hospital and home care agencies belonging to a private nonprofit corporation in the Midwest provided data. A total of 136 surveys were used in data analysis; 57% of distributed surveys were returned.

Differences between the hospital and home care staff nurses were not found. Self-perception, difficulty in applying clinical behaviors to the MLQ, unknown aspects of leadership or followership, or measurement limitations may have affected the results. The findings provide support for the premise that staff nurses use a variety of transformational and transactional behaviors, although at levels below those demonstrated in prior literature. Among the respondents, 75% used exemplary followership, 22% used a pragmatist style, and 3%, a conformist style. Nurses in this sample did not use alienated or passive followership style. Further study looking at the effect of setting and at factors affecting leadership and followership behaviors in staff nurses is recommended. All levels of nursing should address the discrepancy between the conceptual leadership expectation for the staff nurse and what the staff nurse perceives and demonstrates. Finally, the profession should develop models of
leadership and management that incorporate clearer definitions of such behavior and how these behaviors can be seen in the clinical arena.
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ACKNOWLEDGMENTS

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Elaine S. VanDoren
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CHAPTER I

THE PROBLEM

The Need for Strong Leadership and Followership

In the last 10 years, a revolution has been occurring in America that has led to fundamental changes in the way health care is organized, financed, and delivered. Daily, new challenges arise that affect the ability of health care providers to meet the public's need for high quality, cost-effective care. The nursing profession, as the largest provider of direct health care workers, is in the vanguard of this movement. Given the current and future system revisions occurring, change appears unprecedented at all levels of practice. This intensity and magnitude of change can lead to chaos or growth for the nursing profession and for its practitioners. Strong leadership and followership occurring in tandem can play a role in such change, ensuring the well-being of both. Leaders can effectively initiate transformation of their organizations (Tichy & Devanna, 1986), and leaders who are also strong in followership skills enhance their power to achieve it.

Throughout history, leaders have been recognized as important to development. Whether the challenges have been great or small, leadership, along with environment and organizational forces, has played a major role in the satisfaction of the group endeavor (Bass, 1990a). However, as important as leadership is, it alone does not provide the total answer to achieving and maintaining success in any organization. Review of past research on leadership suggests a tendency for people to
exaggerate the effect of leadership on performance (Yukl, 1989). Increasingly there is recognition that leadership behavior is only one part of the equation, skills in followership also play a pivotal role.

Followership as conceptualized in the 1990s is, however, quite different than prior perspectives. Recent literature refocuses the behaviors of followers from the passive, sheep-like descriptions common in prior times to an active, energetic state. The “new” followership includes behaviors that incorporate critical thinking, initiative, balance, and commitment (Murphy, 1990). Such followership, according to Robert Kelley (1992), comes from people of exceptional ability who know how to lead themselves. This kind of followership can be an important factor in the success of any organizational endeavor.

Now is the time for proactive leadership in the profession (Barker, 1992). Such a stance requires a look at the process of leadership in organizations providing nursing service. It is important that this look take into consideration the larger view expressed by other leadership experts. Nursing should not separate itself from the paradigm of the greater body of leadership theory; instead, it would better serve nurses and clients to actively integrate such principles into the profession in a meaningful way.

Use of theory, including accurate application and integration, requires consideration of settings and situation. This study is meant to add knowledge about the leadership process in nursing since nurses work in a variety of settings. Specifically, the purpose of this work is to explore the behaviors of leadership and followership that are used by staff nurses in different settings while answering the question: Do staff nurses employed in hospitals use different leadership and followership behaviors than staff nurses employed in home care agencies?
Nursing Background

The practice of nursing has been an activity since the beginning of human existence; the practice of the profession of nursing is of much more recent vintage. Most nursing scholars trace the profession's modern origin to Florence Nightingale and the development of organized schools of nursing in the 1800s. Since then, nursing has substantially been affected by and responded to the changing needs of societies.

American nursing can be viewed from a variety of perspectives. The two that are most relevant to this study include the educational preparation for basic practice and the functional roles taken by practicing nurses. Since educational background is a major factor affecting the study, it will be discussed in depth in Chapter II. A review of the functional roles will present a context for future deliberation.

Nurses do a variety of jobs in many different settings. Regardless of the environment, the purpose(s) of the position or role they assume can be categorized into four functional areas. Traditionally these functional areas are: education, administration, clinical practice, and research. While a case can be made that all practicing nurses take on each functional area in some manner, the perspective underlying this study is that individual nurses have a predominant focus that comprises the majority of their work effort. Thus, the nurse manager may also be involved in research but the majority of the time is spent working through others as an administrator in the organization.

The purpose of this study has been described as focusing on both leadership and followership behaviors of staff nurses. Staff nurses are clinical professionals who work most directly with clients to improve or maintain health. Since this service is the
The essence of nursing practice, the clinical practitioner is often perceived as the real nurse and idealized by the profession (Stevens, 1981). Organizationally, the staff nurse position most frequently reports to a head nurse, a formal leader responsible for a clinical area. Additionally, the staff nurse role functions under the authority of the physician relative to delegated medical areas. See Appendix A for sample job description for a staff nurse.

Given these hierarchical parameters, it is not difficult to propose a follower role for the staff nurse. Unfortunately, followership is often viewed negatively in our culture. In countering this view, recent literature has noted that success in group work requires people in both leadership and followership roles (Campbell & Kinion, 1993; Heller & Van Til, 1982; Kelley, 1992). Effective followership in this study includes those behaviors that contribute to the creation and achievement of the organization’s vision, result in completing the assigned job, and demonstrate an initiative that leads to work improvement (Lee, 1991). Implicit in this study is the belief that excellence in the staff nurse role requires strong, effective followership skills.

In addition to these behaviors, staff nurses have great potential for leadership through the influence of the direct care they provide to a client, a family, or a community. The leadership provided by the staff nurse may be defined as clinical leadership to differentiate it from the administrative, educational, or research leadership components of the functional roles. For this study, clinical leadership is defined as the behavior exhibited by a clinical nurse that influences clients, families, or other health care workers to achieve the goal of providing quality care that is both efficient and effective. Such leadership behavior occurs as an adjunct to the primary activity of providing direct client care.
While many definitions of leadership have been used in various studies, the basis for this definition was taken from a study completed by Jones, Guberski, and Soeken (1986) where leadership was defined as behavior influencing another individual toward a goal. These authors do not believe it is necessary for a nurse to be in an administrative or a managerial position to demonstrate the behaviors of a leader. For this study, the definition was expanded to increase the emphasis on clinical nursing and current practice setting realities. While nurses do practice in many settings, two key settings are the acute care hospital and the home care agency. The acute care hospital environment is the primary employment site for nurses. Though employing fewer in number, home care agencies use nurses to provide and coordinate care in an individual's private home and have become increasingly important as clients are discharged from the hospitals earlier and earlier. An expanded discussion of these practice settings is included in Chapter II.

Rationale for the Study

Limitations of Current Research

Much has been written about leadership in nursing. A preliminary search of the nursing and health care literature for this study led to over 600 articles using only the key words of leadership and nursing in the Medline database. However, review of the citations demonstrated limitations in two areas: the way leadership is defined and a paucity of research.

Discussion of the leadership concept in nursing practice literature, centers primarily on formal or organizationally designated leaders. The terms leader and manager are used interchangeably. An exception to this point is the role of the
advanced practitioner who may not hold a line administrative position but frequently is considered a clinical leader. This concentration of the practice literature can be contrasted with educationally focused materials, which incorporate leadership in some way into the curricula of all the basic preparation programs (Associate Degree, Diploma, and Baccalaureate). Thus, it appears nursing expects to educate entry level practitioners as "leaders," but has not clearly articulated the role or use of such leadership in the clinical setting.

A second deficit identified in the initial review of the literature is the wealth of anecdotal material and the limitation of readily available research-based information. This point is supported by McCloskley and Molen (1987), who noted that their review of the nursing literature from 1966 and 1984 resulted in 200 citations, of which only 58 met the criteria of research-based studies. Currently, the greatest body of leadership research in nursing appears to be in doctoral dissertations and masters theses available through Dissertation Abstracts International. The majority of this material also focuses on the formal leader and the effect of leadership on job satisfaction.

Little literature is available on followership in nursing. The majority of the effort can be extrapolated from the work on empowerment. Lee (1991) notes the empowerment concept describes the dynamics between leadership and effective followers. Ownership, shared decision-making, self-leadership, and shared visioning have been key areas of this discussion (Brown, 1992).

The Case for Studying Staff Nurses

To be effective, leadership must occur throughout a society. Leadership occurs as "vital and concentric rings of secondary, tertiary, and even 'lower'
leadership at most levels of society" (Burns, 1978, p. 5). Thus, while important, it is not enough to have leadership at a global level to promote international efforts. Leadership must permeate institutions, such as the professions, that are integral to each and every culture. From this systems perspective, nursing leadership can be seen as a component of the nursing profession, the health care system; and in this country, as one of American societal forces.

Burns' (1978) concentric rings can be further applied within the nursing profession. Leadership occurs at all levels. From the beginning practitioner to the expert clinician, administrator, researcher, and educator. The venue for the leadership role may change, but the essential components will not. While the leader-follower relationship may take place between the nurse and a client, peer, student, hierarchical subordinate, or fellow practitioner, the nurse will continue to use this relationship as a means of achieving goals.

Accepting the "mantle of leadership" does not always come easily. For example, in a class of RN BSN Completion students taking an undergraduate senior management course, with the average student in the group having at least six years of nursing experience, none indicated an interest in taking management positions after completing the program. When asked by the instructor what leadership roles they had taken in their employing organization in the past year, 28 of the 34 students indicated they had not taken any role. Six others identified some formal management positions. Responses of the group indicated a general anxiety about being a leader and a desire to shift the responsibility to someone else; as demonstrated by one student's comment that "leadership is the role of someone else, like you" referring to the instructor. This comment also sums up what is empirically the major source of nursing leadership, namely, nursing managers in service or educational settings.
Stevens (1981) believes that "this peculiarity, itself, merits inquiry in a discipline where the practitioner is the idealized role performer" (p. 7).

Another nurse has noted that whether or not the staff nurse plans to be a leader in nursing, leading is frequently what he or she ends up doing (Bara, 1987). This is especially true in today's service environments with the focus on participative management, shared governance and quality work teams which are meant to involve every nurse in the full process of providing nursing care. Even if one only considers direct clinical activity, today's economic climate has every nurse involved in the efficient and effective movement of the client from illness to health with "product line management." This view is supported by the Pew Health Professions Commission Report (1995) which recommends that the nursing profession recover its clinical management role and recognize the strength it has for professional practice at all levels.

These two limitations in the current literature along with a strong need for increasing leadership and followership provide a supportive rationale for proposing this study using staff nurses. However, now more than ever before, nurses practice in a variety of settings. It is also important to consider the practice setting for the study.

The Choice of Hospital and Home Care Setting

Throughout the 20th century, nursing has been associated with hospitals. In 1996, approximately 60% of employed nurses worked in that environment (U.S. Department of Health and Human Services, 1997). Not only have such institutions been the center of the practice of the profession, they were also, up to the advent of the community college nursing programs in the 1960s, the major source of education. While academic institutions have taken over the basic undergraduate education to a
significant extent, the hospital remains the major practice setting for students as well as graduate nurses. Such a long and continuing association has had much influence, both positively and negatively, on nurses and nursing. It is for these reasons that the study focuses on the hospital setting as one source of information about leadership and followership behavior.

This proposal also includes home care agencies as a practice setting. The inclusion of such groups is meant to provide a more holistic view of the staff nurse experience occurring during this critical period of health care system change. While hospitals have been the dominant setting for nursing practice in terms of numbers of practitioners, some experts believe the home and ambulatory care settings will be the environment of the future (Barahydt-Wexenaar, 1986; Mitchell, Krueger, & Moody, 1990).

From 1978 to 1988 the number of home health agencies have doubled, while hospital bed occupancy has deceased (Cowart & Speake, 1992). Public and Community Health organizations employed over 362,648 nurses in 1996; 17% of all employed nurses (U.S. Department of Health and Human Services, 1997). This was a 100% increase over the 1992 figure of 182,516 (U.S. Department of Health and Human Services, 1992). Such growth is expected to continue although at a somewhat slower rate. Thus, home care agencies will remain an important setting for nursing practice in the foreseeable future.

Hospital and home care agencies today account for a significant number of nurses in practice as well as employing the majority of the ancillary nurse extenders or nursing assistants. Staff nurses are the front line professional providers of care in both settings. As such, their strength in leadership and followership can have a major
impact on the total health care delivery system as well as on the care of the individual client.
CHAPTER II

REVIEW OF THE LITERATURE

This study was designed to look at the relationship between leadership and followership behaviors self reported by staff nurses and the practice environment and secondarily to explore various aspects affecting these behaviors. The term practice environment includes both hospitals and home care agencies, the two major employment opportunities for staff nurses today. The topic of leadership itself is complex. Adding consideration of the construct of followership, and to a specific professional area such as nursing, increases the complexity significantly. To present the literature in a meaningful way, the review will begin with a discussion of leadership/followership models, move to the nature of nursing and the educational programs that prepare nurses, and then focus on the staff nurse. Lastly, the two practice settings, hospitals and home care environments, will be discussed. The summary will bring together these ideas and present the research hypothesis.

Theoretical Models

An Overview of Traditional Leadership Models

Leadership has been studied from a variety of perspectives over the years. Yukl (1989) states that the majority of leadership research can be categorized into trait, power/influence, situational or behavioral models. Each of these models have been used to study leadership in the context of professional nursing.

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Trait theory places the focus of research on the individual characteristics of the leader. Some of the earliest research of the 20th century focused on this area. To date, a wealth of specific characteristics that exist in leaders, especially when compared to nonleaders or ineffective leaders, have been empirically validated. A factor analysis of the traits of leadership found in research studies from 1945–1970 (Bass, 1990a) lists 26 such items. Such areas as “technical skills, friendliness, task motivation, interpersonal skills emotional balance and control, effectiveness and achievement are most frequent, while aloofness, maturity, informal control, nurturance, occur less frequently” (p. 85).

In nursing, this model has been used by Dunham and Fisher (1990) in profiling nurse executives. Using qualitative methods, findings identified traits of leadership, such as strong value systems, charisma, vision, integrative ability, and creativity developed as themes from the data. According to McCloskey and Molen (1987), the relationship between personality and leadership has been studied most often as a way of predicting leadership.

Research on power and influence focuses on sources of power and the relationships between power, influence behavior and leadership effectiveness (Yukl, 1989). The work of French and Raven (1959) provided the basis for a taxonomy that categorized power as reward, coercive, legitimate, expert, and referent. These concepts have in turn been studied extensively as they relate to their use by leaders. Research suggests that effective leaders rely more on personal power; the amount of positional power needed depends on situational factors; the manner in which power is exercised affects the success of an attempt to influence; and leaders develop different exchange relationships with different individuals (Yukl, 1989). While several studies have looked at power in nurse administrators, a recent study by McMahon (1990)
compared power relationships among nurses working on units that had typical management structures with those that had primary nursing decentralized structures. Analysis of the observational data supported differences in the nature of the power relationships between the typical and decentralized units. For example, on decentralized units, primary nurses were more often seen discussing and following up on patient problems while nurses on the hierarchical managed unit did not follow up or referred the problem to others. Other statistical analysis supported increased collaborative communication on the decentralized units as well. The type of unit specialization did not have an effect on the frequency of a collaborative type of communication.

Situational leadership encompasses a number of theories that focus on the conditions of the leader-group interaction and the environment. Most notably are (a) the Path-Goal Model (Evans, 1970; House, 1971) and (b) the Situational Leadership Theory by Hershey and Blanchard (1988) and Fiedler’s Contingency Theory (1978). The Path-Goal Model, according to Marriner-Tomy (1994), suggests that a leader can influence workers by both reducing barriers interfering with work and providing reinforcement for work well done. The environment of a situation will determine the type of leader behavior that will result in accomplishment of the path-goal purposes. Contingency Theory, described by Fiedler in the 1970s, focused on how the task and relationship orientations of leaders were affected by the demands imposed by the situation (Bass, 1990a). The last major situational model, the Life-Cycle Model by Hersey and Blanchard (1988) examines how the leader handles relationships and tasks in light of the maturity of the subordinate. Using the maturity of the worker as a variable, the best leadership style can be chosen from a continuum of high to low relationship and task.
These three leadership theories all focus on the relationship between the leader and some other aspect of the situation. According to Bass (1990a), Path-Goal Theory places the task, environment, and individual differences as the factors that affect the situation. In Contingency Theory, leadership is impacted by leader-member relations, task structure, and positional power (Marriner-Tomy, 1994). In the Hersey and Blanchard model, the maturity of the individual, (low, moderate, or high) affects the type of leadership style that will be most effective. The factors taken into consideration, whether they are environment, follower, or task characteristics lead to the differences between the three.

At various times, all three theoretical frameworks have been used in nursing studies (Altieri & Elgin, 1994; McCloskey & Molen, 1987). One study based on Hersey and Blanchard (1988) explored the effect of management training on nurse managers (Johnson & D’Argenio, 1991). Using a pre/post design, this study found support for short-term effects but little evidence of long-term effect for the training intervention.

Leadership has also been studied using a behavioral approach. Studies using this approach focus on differences between effective and ineffective leaders relative to the leader’s conduct. They cover such concepts as task and relationship orientation and participative management. Developing out of the seminal Ohio State leadership studies of the 1940s and 1950s, one of the most well known behavioral approaches centers on the issues of structure and consideration. Recent conception has expanded the framework to 12 aspects of leadership which have been used and reported extensively in the research literature (Bass, 1990a). One pertinent example, a doctoral dissertation by Roe (1989), focused on developing a staff nurse leadership behavior model to look at relationships between various organizational and individual factors.
as well as leadership behaviors. She reported that staff nurses did not demonstrate the level of leadership behavior expected by the role described in the literature, but suggests that staff nurses may demonstrate leadership behavior in ways related only to delivering client care.

Recent approaches to leadership has theorists combining two or more elements from other theories to produce a less focused approach but one that provides greater explanatory ability. According to Yukl (1989), this demonstrates an attempt to avoid the early segmented research that focused on one area, for example, traits, or specific leader situations. Examples of combined approaches include the work of Bennis and Nanus (1985), Tichy and Devanna (1986), and Bass (1985). Bass’s work, called Transformational-Transactional Leadership, combines trait theory by incorporating inspiration and charisma; specific leader behaviors, with intellectual stimulation, individual consideration, and management by exception; and elements of the Path-Goal Theory with the concept of contingent reward (Bass, 1986). This leadership theory, described in detail below, provides the framework for this study.

Bass (1990b) uses transactional leadership as a contrast to transformational approaches. Transactional leadership is “effective” leadership in which “the leader gets things done by making, and fulfilling, promises of recognition, pay increases, and advancement for employees who perform well. By contrast, employees who do not do good work are penalized” (Bass, 1990b, p. 20). Characteristics associated with transactional leaders include contingent reward, management by exception, and laissez-fair. Leaders can be both transformational and transactional depending on the situation and the circumstances.
Transformational Leadership in Depth

Burns (1978) first coined the term *transformational leadership* to describe a process in which leaders and followers raise one another to higher levels of motivation and morality. He contrasted this type of leadership with transactional, a type of leadership that motivates followers by appealing to their self-interest. Bass, who expanded on the work of Burns, defines transformational leaders primarily in terms of the leader's effect on followers. According to Bass (1990b), transformational leadership is "superior leadership" which occurs when leaders broaden and elevate the interest of their employees, when they generate awareness and acceptance of the purposes and mission of the group and when they stir their employees to look beyond their own self interest for the good of the group. (p. 21)

Several characteristics are associated with transformational leadership; these are charisma, inspiration, intellectual stimulation, and individualized consideration. Bass believes the construct of transformational leadership explains more fully leader-follower relations, motivation, and effectiveness. An important principle of his theory is that transformational leadership behaviors increase leader effectiveness and subordinate satisfaction.

Bennis and Nanus (1985) have also based their work on the transformational concept by Burns. Using interviews and observations, these authors worked with 90 leaders; of these, 60 were successful CEOs and 30 were outstanding leaders from the public sector. Criteria for inclusion were based on financial viability, reputation among peers, and outside experts. Only three questions were asked of all participants: "What are your strengths and weaknesses?" "Was there any particular event in your life that influenced your management philosophy?" "What were the major decision points in your career and how do you feel about those decisions
Using these questions as starting points, unstructured interviews were held with the leaders. Although responses were diverse, after Bennis and Nanus analyzed the data, they identified four "keys" that describe effective leadership, that is, transformational leadership. The keys are: (1) attention through vision, (2) meaning through communication, (3) trust through positioning, and (4) the deployment of self. Underlying these keys are the concepts of charisma, team or organizational focus versus self-interest, and higher levels of need attainment, such as self-actualization and self-esteem. The keys may be thought of as the "how to's" of transformational leadership.

Not all researchers have agreed with transformational theory. Major criticisms focus on the research methodology rather than the theory itself. For example, Yukl (1989) believes the transformational measuring instrument (MLQ) has limitations of measurement and methodology. However, more recent changes in the tool have been made to address these areas.

**Transformational Theory and Nursing**

Is transformational leadership a valid model for research on leadership in nursing? Several nursing leaders believe so. They have specifically identified the transformational leadership model as a paradigm in the postmodern nursing organization based on the rapid changes going on in the health care system (Barker, 1992; Koerner & Bunkers, 1992; Porter-O'Grady, 1992).

Additionally, other nurses have suggested the concepts that should be part of a nursing leadership model—concepts that are integral to the transformational model. Ryan (1990a) believes that the basic concepts of a strong model should include collaboration and coalitions, increased cooperation, shared resources, networking,
and creative approaches to management of staff. Nurse educators have suggested that it is important for the profession to increase its integration of business concepts, research, and approaches in the nursing leadership curriculum (Foster & Boestler, 1990; Wagner, Henry, Giovinco & Blanke, 1988). Transformational leadership with the emphasis on intellectual stimulation and motivational interpersonal aspects incorporates many of these important ideas. Increasingly, discussion of this model is seen in the nursing literature.

In the research arena, from 1966 to 1983, nursing leadership study mirrored the broader perspective focusing on trait, behavioral, and situational models and focused on defining leadership and leadership effectiveness (McCloskey & Molen, 1987). Literature from 1983 to 1993 showed continued interest in situational models, definition and effectiveness with interest in predicting leadership an added element, and in 1990, the introduction of the transformational model. A variety of nursing studies have been done incorporating Transformational Theory; several of these will be detailed.

Dunham and Klafehn's (1990) exploratory study looked at a convenience sample of 80 nurse executives considered excellent by their peers. The nurse executives were from hospitals in 30 states and represented every region of the country. An executive was included upon recommendation by peers, by faculty from the nursing administration division of schools of nursing or by other nursing administration staff. The contacts were allowed to name as many people as possible. Certain names came up repeatedly and these were identified as a priority for inclusion in the study. Names that occurred less frequently were included on a convenience basis.
The study used both the self and staff versions of the Multifactor Leadership Questionnaire (MLQ), developed by Bass, to measure transformational and transactional leadership. The researchers reported that the nurse executives used predominantly a transformational leadership style with the executive scores significantly higher than the staff scores. Overall, the nurse executives' transformational scores were higher than those achieved in Bass's studies of world leaders, administrators, and managers. Relationships between transformational scores and demographic characteristics were not found, except in one important area—education. Persons with advanced degrees, both at the masters and doctoral levels, had higher transformational scores. When looking further, nurses with a master's in nursing versus a nonnursing master's had a higher transformational score, but their basic educational program had no relationship to the level of the transformational score. This study was limited by the convenience sample and the authors suggest more cross-sectional studies to determine if the transformational style is predominant for every nurse leader in an executive position.

McDaniel and Wolf (1992) carried out a study that tested four hypotheses regarding the applicability of transformational theory to nursing practice in hospitals. Hypotheses proposed were: higher transformational scores in the top echelon of nurses, nurse executive self-assessments higher than those of followers, average or above average staff nurse satisfaction in high reported transformational score agencies, and low staff nurse turnover. Using a descriptive cross-sectional survey method at one moderate-sized hospital, the Multifactor Leadership Questionnaire (MLQ) and the Work Satisfaction Scale were completed by 46 registered staff nurses and 9 mid level nursing administrators. All hypotheses were supported. The authors,
while noting the limitations of a convenience sample and single site, conclude that the study results support the assertions of the theory and add support to prior studies.

Using a different perspective, McDaniel and Patrick (1992) carried out a pilot study that used the MLQ to look at leadership and considered turnover and nurse/patient satisfaction. A correlational research design was used with a convenience sample of 10 medical surgical units in one hospital. Hypotheses and findings were: (a) an inverse relationship between RN turnover and patient satisfaction, supported; (b) positive relationships between head nurse leadership style and RN satisfaction, not supported; and (c) leadership and RN work satisfaction, supported. In addition to concerns with the one site sample, this study is limited by the report which lacks detail and clarity in the analysis of the findings for the hypothesis on leadership.

An ex-post-facto design was carried out by Young (1992) who looked at the degree of transformational leadership present and the educational experiences of 66 nurse leaders from 11 hospitals. Both quantitative and qualitative data collection measures were used. Twenty-five out of the 66 respondents were high on the transformational scale, while 29 were moderate, and 12 low. When looking at educational experience, significant differences were found between the high, medium, and low transformational leadership groups, between the amount of informal education, formal content, and formal strategies. That is, transformational leaders experienced more informal education, more formal content, and varied teaching strategies in their own educational backgrounds. While this study used Burn's transformational model (1978) as a theoretical base, it is not clear whether it incorporates the expanded Bass concepts (1990a); the leadership measuring instrument was the Leader Behavior Questionnaire (LBQ) developed by Sashkin.
Additional studies outside of nursing have shown this model as being most relevant to women. Alimo (1995), in a sample of business managers, looked at the ways in which male and female respondents described their constructs of leadership. The descriptors of women related "directly to notions of transformational leadership and men's to transactional leadership." Rosener (1990) says that women are far more likely to describe themselves as transforming and to carry out activities that develop subordinates self-interest toward a greater organizational good than are men. Since the majority of nurses are women, the transformational model of leadership may be most consistent with their conceptualization of what leadership is.

To summarize, a variety of studies have been carried out using the transformational theory since the inception of that term by Burns in 1978. Outside of nursing, the work has been developed by Bass and a variety of co-authors, along with Bennis and Nanus (1985), who provided extensive description of successful public and private leaders. Nursing literature shows a developing foundation for using the model in nursing practice settings. These studies focus on formal leaders, that is, nurses executives and managers. Research findings thus far support the relationship between transformational leadership and organizational effectiveness and between transformational leadership and staff satisfaction. Secondly, findings indicate support for transformational leadership having higher correlations with patient satisfaction outcomes when compared to transactional leadership behaviors. While findings support theory application, the studies are limited by convenience or one-site samples. In addition, a variety of methodological concerns exist, most are common to the study of leadership in general.
Followership Models

Followership, in contrast with leadership, is both conceptually and empirically less developed; a situation that may have developed because the traditional perspective on followership is hardly one that is desirable and valued. This view has been well summarized by Rost (1994), who, while rejecting the term followership in favor of collaborators, notes:

The common wisdom is that followers are to do followership, which means that they are to do the leader’s wishes. The responsibility is to follow the leader, who shows them the right thing to do. Followers are basically passive, subordinate, submissive, more or less unintelligent, not in control of their lives, and unproductive. They need leaders to show them the way, to lead them down the right path, to direct them in various situations, to guide them in making decisions, and to articulate a vision for them. Followers are not capable of doing leadership, so they are left with doing followership. (p. 2)

Given this perspective, it is not surprising that followership has received scant attention when compared to leadership. However, this situation is changing. In the 1990s, not only does more of the leadership literature stress followers, but also more writing focuses solely on followership and related areas. Wortman (1982) noted that leader-follower roles were changing and suggested that corporate America would only benefit. Lippitt (1982) is even more direct about a negative side. He states:

Our major unused human resource is the very large proportion of followers who use the group and organization as a way to hide from actively taking responsibility and who use their alienation and apathy as a basis for functioning at a low level of energy and initiative. (p. 400)

Within the nursing profession, Fralic (1993) included followership as a centerpiece characteristic for the new nurse executive. But Murphy (1990) notes that the current concept of followership must be changed and that a leadership role should not be considered superior to a follower role. Both, she says, are “equally important and necessary to the work of nursing” (p. 69). The concept of followership discussed
in the recent literature is quite different from the traditional model previously described.

In “Beyond Leadership . . . The Importance of Followership,” Lundin and Lancaster (1990) provide a description of the new model of followership. They say that the characteristics of the follower are not that much different than the characteristics one finds in leaders. Specifically,

Effective followers must possess a high level of organizational understanding in order to see how their work contributes to the big picture. They must be able to make sound decisions, often through teamwork that requires a high level of communication. They must be enthusiastic about what they do to the point that roadblocks and repetition don’t deter them from achieving their objectives. They need to feel a strong level of commitment, both to the organization and to their own work. And, finally, they must be highly responsible individuals who are willing to perform under stressful circumstances, motivated by the sense of a job well done. (p. 19)

This description requires characteristics quite different from those that would flow out of the traditional perspective. Lundin and Lancaster, reporting their research on successful followership, identify integrity, owning the territory, versatility, self-employment, and value integrity as key characteristics. Kelley’s (1992) characteristics are quite similar, although he uses different terms. He says that effective followers manage themselves, are committed to the organization—to a purpose, principle, or person outside of themselves, have competence, focus their efforts, and demonstrate courage, honesty, and credibility. All of these qualities are ones that would be valuable in the changing world of health care.

Since this is a new perspective, it is not surprising there is relatively little research-based literature. One notable exception is the study by Gilbert and Whiteside (1988). Using their own followership effectiveness assessment, they surveyed 500 police officers to identify the characteristics of effective followers and test the relationship between effective followership and other performance measures. Nine
dimensions of followership were associated with positive performance and relationships were found with promotions and general rating performance. The dimensions included such qualities as job commitment, sense of humor, dependability, positive working relations, ability to speak up, technical competence, and appropriate professional behavior. Interestingly, high followership did not necessarily correlate with the ratings received as part of the formal performance appraisal system.

Another relevant study assessed productivity and evaluated a training program in the Bell system research and development laboratories (Kelley & Caplan, 1993). To assess productivity, interviews were conducted with both average and top performers. Nine work strategies which included such behaviors as initiative, networking, and self-management, were identified as being related to high productivity. Following this part of the study, an expert model and training program was developed that incorporated the initial findings. Further study focused on comparison of 300 employees who participated in training with 300 employees who had not participated. In the group which participated, productivity self-report showed increases of 10% immediately after training, 20% after 6 months, and 25% after 1 year. Report from supervisors in the treatment group showed productivity increases in handling problems, getting work done on time with high quality, pleasing customers and working well with other departments. Average performers as well as star performers demonstrated similar rates of benefits. Unfortunately, the article reporting the study lacked research detail; it was published in the general business literature.
Kelley's Followership Framework

Kelley's work (1992) on followership will be used as the conceptual model for this study. Developed out of interviews with followers from different life perspectives, Kelley's model is based on two dimensions— independent critical thinking and active engagement. Both of these dimensions developed out of the characteristics Kelley identified associated with effective followers: self-management, commitment, competence, and focused effort, as well as the qualities of courage, honesty, and credibility. Placing the two dimensions of independent critical thinking and active engagement on intersecting axis results in five followership styles: (1) exemplary, (2) alienated, (3) conformist, (4) pragmatist, and (5) passive.

Exemplary followers manage to balance the two requirements of independent thinking and active engagement. When Kelley presents the work of exemplary followers, he notes that they use their independent thought to the greater good of the organization. They provide some of the best thinking in the organization, often taking the less popular side to provide alternative ways of viewing a problem. Yet, they remain actively engaged such that a successful conclusion can be developed.

Alienated followers, while able to use independent critical thinking, have difficulty with the dimension of active engagement. Kelley suggest the popular figure of Hawkeye Pierce, from the television series M*A*S*H as an alienated follower. Capable and cynical, alienated followers sarcastically criticize the leader's efforts while holding back on their own effort or passively agreeing to the activity. Their anger and hurt often encourages retaliation by supervisors. Kelley believes alienated followers were once exemplary followers who have had negative experiences. Most importantly, he believes they can become successful followers once again by
overcoming their hostility, leaving behind the old negative behavior and refocusing their positive energy.

The conformist follower scores high on active engagement but low on independent thinking. They often find themselves saying “yes” when they want to say “no.” In many cases, they have accepted the old definition of the follower which says critical thinking or challenging is not their job. Indeed, many conformists become frightened of independent action with its concomitant freedom and responsibility. This role has also been strengthened by a society that encourages conformity. Developing critical thinking skills and learning to deal with conflict can promote the development of a worker from a conformist to an exemplary follower.

Passive followers are the exact opposite of the exemplary follower. They score low on both dimensions, favoring neither independent thought or active engagement. Passive followers look to others to tell them what to do and do their work without enthusiasm. Kelley (1992) believes many passive followers are “simply people who haven’t developed their followership skills” (p. 123). By learning and the practicing the exemplary skills, the passive follower can shift to more effective patterns.

The pragmatist lies within the middle of the followership quadrants. While they question and think for themselves, pragmatists make sure they do not offend those they see as important. They perform their work well, but seldom go beyond that. In sum, they work to maintain their own survival and safety rather than attempting to promote the organization. Kelley believes the behavior of the pragmatists develops out of unstable organizations as well as out of their own personality. For the pragmatist, fully utilizing their talents for others, as well as themselves, can help them develop into exemplary followers.
Published followership literature is primarily not research based. With few existing studies, the work is apt to contain minimal documentation of the research methodology. Consequently, the framework seems ripe for more focused study. As DiRienzo (1994) notes, education for followership has been recommended by a growing number of authors within and without the nursing profession. Additionally, she suggests that an increased focus on followership would free novice practitioners of the burden of leadership until they have developed the maturity and experience that years of practice can bring. Many novice nurses are employed in staff nurse positions, a role that may allow them to also develop into exemplary followers.

The Nature of Nursing Practice

Introduction

According to the American Nurses Association (ANA) (1995), nursing exists within a social contract between itself and society. A part of this contract is the professional and legal regulation that sets parameters for practitioners. The nursing profession has two levels of licensed nurses: Licensed Practical Nurses (LPN), and Registered Nurses (RN). However, the focus of concern for this study is the Registered Professional Nurse (RN), the nurse group holding an independent license. For this group, the legal parameters take the form of the Nurse Practice Act, developed by individual states. In the State of Michigan, the legal practice of nursing means:

the systematic application of substantial specialized knowledge and skill derived from the biological, physical and behavioral sciences to the care, treatment, counsel, and health teaching of individuals who are experiencing changes in the normal health process or maintenance of health and the prevention or management of illness, injury or disability. Registered Nurse functions include teaching, directing, supervising of less skilled personnel in
the performance of delegated nursing activities. (Michigan Nurses Association & Michigan Board of Nursing, 1992, p. 15)

In addition to legal regulation, the nursing profession engages in professional regulation to meet its contract with society. Professional regulation provides guidance by developing the scope of nursing practice, the code of ethics, standards for practice, systems of education and credentialing, and the means of evaluation and research. As described by American Nurses Association (1995), nurses in basic practice “provide care for patients and families” in various settings, “intervene to promote health, prevent illness or assist with activities that lead to recovery from illness or to achieving a peaceful death,” “initiate treatment by themselves or carry out interventions initiated by advanced practice RNs or other licensed health care providers,” and coordinate care by integrating “the processes of patient service delivery, patient preparation for various tests or procedures, and the monitoring of patient responses to nursing interventions and the interventions of other health care providers” (pp. 13–14).

The ANA goes on to say that the extent to which any particular nurse engages in the practice of nursing is defined by the nurse’s knowledge, the role, the nature of the client population, and the environment or setting in which the nurse practices.

In addition to these regulatory considerations, the nature of nursing is affected by other elements of the health care system. In today’s complex world, a variety of professions and disciplines interact with nursing to meet societal needs. Thus, nurses collaborate with physicians, social workers, pharmacists, respiratory therapists, and others with the ultimate goal, the provision of health care. Health care means the composite of planned care provided by interdependent professions (each of
whom have their own defining characteristics and independent functions) whose
members work together to meet the needs of individuals and groups being served
(ANA, 1995).

Educational Preparation

Entry into the profession as a Registered Nurse occurs primarily through one
of the three major educational pathways, that is, through a diploma, an associate
degree in nursing (AND), or a baccalaureate degree in nursing (BSN). The three
options vary by the amount of course work required and the type of nursing,
professional or technical.

The lack of a specific educational requirement for licensure is both a boon and
a problem for the profession. While it encourages a diverse Registered Nurse pool,
provides upward mobility options, and maintains a constant source of prepared
professionals, this educational situation also creates a professional ambiguity
regarding the nature of professional nursing. For countless years, the profession has
attempted to deal with this issue without success. In 1965, the American Nurses
Association proposed that the BSN become the minimum educational requirement
for the professional registered nurse with nurses prepared at the ADN or Diploma
level as technical nurses. The negative reaction of the predominant diploma-prepared
RNs was massive, especially since all levels continue to take the same RN licensing
exam. Even today, with a significant number of BSN prepared nurses, this proposal
remains unfulfilled.
Nursing Educational Programs and Leadership

The National League for Nursing (NLN), a professional organization which focuses on nursing education and research, has provided statistical information and descriptions for the three educational pathways as follows.

Diploma Programs

Of the 1,501 nursing programs in the United States, there are 124 Diploma programs (NLN, 1996). Once the primary education for nurses, these educational programs are hospital based and require a course of study between two and three years. According to NLN, graduates usually assume staff positions in hospitals and advancement is not likely without additional educational preparation. Some diploma programs are affiliated with junior or senior colleges for specific course work. Nurses who want to advance their degree will need to demonstrate by examination or by documentation that they are qualified to advance.

Associate Degree Programs

Associate Degree Programs, the largest group at 867 programs, are based in junior or community colleges (NLN, 1996). Requiring approximately 64 credits, this program includes course work in basic human sciences and nursing. According to NLN, graduates are prepared to function in structured care settings, such as hospitals and nursing homes. They do not have the career advancement opportunities available to BSN graduates, but they constitute the largest source of new nurses. Many colleges and universities have specific articulation programs to allow the ADN prepared nurse to earn a BSN.
Baccalaureate Degree Programs

Baccalaureate degree programs, numbering 508, require 120 to 128 credits and are affiliated with 4-year colleges or universities (NLN, 1996). Course work typically combines physical science, humanities, and social sciences courses with the professional nursing courses that have a strong theoretical core. Graduates are employed in a variety of patient care setting including hospitals, community agencies, schools, and clinics. As the first professional degree, the BSN allows additional preparation at the master's and doctoral levels.

Potential nurses are encouraged to choose their educational pathway based on financial resources, academic capabilities, and long-term goals (NLN, 1996). Nationally in 1994, 94,870 individuals graduated from the basic RN programs. Of these, 28,912 or 30% were baccalaureate graduates, 58,839 or 62% were ADN graduates, and 7,119 or 8% were Diploma graduates.

Within the profession, there is widespread acceptance that the multiple educational pathways lead to different competencies. Educators from each program claim to provide the practitioners with different skill bases for nursing practice. All too often such statements reflect personal preference rather than critical judgment or disciplined inquiry. Diploma nurses are often seen as the most prepared practitioner with more technical skills. ADNs, due to their shorter program, may be considered a ready and able supply of basic skills. Baccalaureate nurses may be perceived as lacking technical skills but having high leadership potential and a theoretical base.

Increasingly, the profession has begun to articulate a reasoned conceptual basis for the educational differences. In most cases the differentiated competency statements involve the two most common programs, the ADN and the BSN. One
such conceptual framework was developed by Primm (1987) who suggests different competencies for three areas, direct care, communication, and management. A review of the competency statements support the ADN focus on structured settings, with basic skill development. Words such as established formats, lists or goals, participation in the plan of care, modifying and implementing the teaching plan, working with well defined nursing diagnoses, and working with other health care personnel suggest a limited role with narrowly defined behaviors. The BSN prepared nurse is described as working with aggregates and community groups as well as with families and individuals. Competency statements use words such as expanding formats, lists, or goals, interpreting the plan of care, developing nursing diagnoses and a comprehensive plan, and assuming a leadership role in health care management when working with other health care personnel. Thus, Primm’s approach is consistent with the NLN perspective of the educational process.

A review of curriculum content (National League for Nursing, 1991) demonstrates similar differences in wording of educational material. Curriculum content for baccalaureate education focuses more on leadership, collaboration, and research when compared to associate degree curricula (McMillan, 1985). Manfredi and Valiga (1990), however, in their study of BSN curricula, report that faculty focus most of their effort on management training rather than leadership development despite articulating a difference between the two.

Are these conceptual differences played out in the practice world? Unfortunately, there is no definitive answer. Studies imply a plethora of methodological approaches with mixed results (Rose, 1988). Rose found 14 studies that attempted to look at leadership in relation to education and found that baccalaureate nurses did not consistently score higher than Associated Degree nurses.
One study by McMillan (1985) used the Professional Performance Examination, which is a measure of nursing competency. The four subtests of leadership, collaboration, research, and management of client care are expected to produce higher scores for baccalaureate graduates. Using two alternate forms, the test was given to 86 subjects from ADN programs and 83 subjects from BSN programs. Both groups were 6 weeks from graduation. Data analysis was not able to lead to any conclusions about differences between the two levels of education except for higher scores on the research subtest in BSN-prepared nurses.

In 1989, Lynn, McCain, and Boss used the Schwirian's Six Dimension Scale of Nursing Performance (Six-D) and the Nurse's Professional Orientation Scale (NPOS) in their 5-year longitudinal study that compared the socialization of 30 RNs returning for a BSN with 193 generic BSNs. Both instruments have adequate evidence of reliability and support for validity. No differences were found using a t test to compare NPOS entry and exit scores for the RN to BSN group, whereas differences were found on a t test for generic student entrance and exit scores. Using ANOVA, the NPOS program entry scores across the two groups were compared and found to be different in all of the scales, with the RN BSN student higher in all levels. The analysis of the exit scores, also using ANOVA, failed to show an differences. The researchers further analyzed the data after statistically removing the effect of the program entry NPOS scores. In the results, RN BSN students have lower program exit scores than do the generic students. The authors go on to note that based on the NPOS, RN BSN students did not change significantly during the time of their baccalaureate education, while the generic students changed and came even closer to the professional referent scores used to interpret the tool.
Program entry and exit Six-D subscale scores were also analyzed using a t test. For the RN BSN group, differences were found in the critical care, teaching, collaboration, interpersonal and professional development areas but no differences were found in leadership or planning/evaluation. The generic students had significant changes at program completion on all of the Six-D scales except the professional development scale. Using ANCOVA to control the program entry scores, the researchers found that the only difference at exit was in the professional development area. Since the BSN student entered into the program with a higher level of leadership but exits the program with the same or similar level, the relationship between education and leadership remains confusing. Perhaps education does not increase leadership but rather RN BSN programs attract individuals with greater leadership competencies or interest to begin with. No mention was made by the researcher of any possible effect the student role had on the findings. Additionally in this study, leadership skills, or the 6-D instrument, at some point appears to stop showing measurable changes, while the NPOS may have less sensitivity to maturational changes occurring in the RN BSN than those occurring in the generic student.

Neylan (1990) found that graduates of different baccalaureate programs are comparable and that experience and position affect leadership behaviors used. Two hundred and fifty-two nurses who had graduated from seven different baccalaureate programs were separated into three separate tracts: (1) generic graduates, (2) RN graduates of traditional BSN programs, and (3) RN graduates of upper division BSN (two plus two) programs. Using the 6-D, generic graduates rated themselves lower on the leadership, critical care, and teaching/collaboration subscales than did the RN BSN graduates. Graduates holding a staff nurse position reported fewer leadership
behaviors than graduates holding management positions. Also, experience affected leadership with the graduate having more than 10 years of experience reporting more leadership behaviors.

Hartman (1994) also studied leadership competencies and academic preparation in first-line managers. In a sample of 129 registered nurses in first line management positions, she was not able to draw conclusions about differences among the three educational programs (ADN, Diploma, and BSN) relative to the competencies measured.

Staff Nurses

The Work They Do

Regardless of the educational preparation of the nurse, the first job position most frequently taken is one of the staff nurse. Staff nurses may, at the most basic level, be defined as clinical practitioners. The adjective “clinical” refers to the functional area of nursing that has as its main purpose the provision of care to clients. Clinical nursing is the core nursing area; the other functional areas traditionally include administration, education, and research. Clinical nurses work in a variety of settings, including hospitals and home care agencies. The vast majority of their time is spent in direct contact with clients who may be individuals, groups or communities.

The nursing literature is replete with the term staff nurse; however, it is rarely, if ever, defined. As noted, the profession has several educational programs all leading to this first level of practice. In addition, the multiplicity of roles now taken by the nurse could lead to confusion if the generic term staff nurse is used without explanation. For this study, staff nurse is being defined as: A registered nurse with a
diploma, associate degree or baccalaureate degree in nursing, working in a health care setting who has direct client contact and carries clinical responsibility for planning and implementing nursing care interventions for a client or a group of clients.

According to Kovner (1995), the typical hospital staff nurse spends the day providing direct care for 6 to 10 patients. Direct care includes: personal care such as bathing, administering of medications and/or treatments such as intravenous fluids or dressing changes, teaching about health or illness, and assisting a client in making lifestyle changes that will improve health such as smoking cessation programs. In addition to direct care, staff nurse are also care integrators. In this role, staff nurses manage communication and coordination of activities of other caregivers. They organize care across hospital department including radiology and laboratory and they are usually the first to recognize emergency conditions, mobilizing others to respond (Kovner, 1995).

Kovner goes on to indicate that the staff nurse in a home care agency performs many of the same activities as the hospital staff nurse. However, there are major differences between the two types of practice setting. In home care, there is a greater focus on the client and their family assuming care responsibility and the nurse functions with more independence. The work environment, role of the nurse, and client issues are unlike those of the hospital (Dreher & Caputi, 1996; O’Neill & Pennington, 1996). Work environment issues surround the physical environment of the client’s home, peer support, access to supplies, and safety concerns. The focus of the nurse changes from a more narrow day to day orientation to one where care coordination, independent decision-making, and knowledge of community resources becomes paramount. Client issues such as the extended nature of the nurse-client
relationship, involvement of family members or other caretakers, and social support for the patient must also be approached.

Staff nurses are the largest group of registered nurses; 67% of all employed nurses use this title (U.S. Department of Health and Human Services, 1992). In addition to being the largest group, they are also the front line of nursing practice. To illustrate, it is the staff nurse that at 2 a.m. provides support to a new mother and her child, carries out minute by minute client monitoring using highly sophisticated equipment in the critical care unit, provides the assistance that can help the elderly diabetic remain at home, and who frequently makes decisions that constitute life or death for the hospital patient. All staff nurses carry out these and a variety of tasks in their role as providers of care. Staff nurses go further than the technical skill that is basic to nursing care, attempting to influence their clients, families, and other health care team members from that direct care position. These actions are the essence of clinical leadership.

Clinical Leadership

Definitions of such leadership can be a dilemma for the researcher. Bass (1990b) notes that for effective research application by a specific group, definitions should evolve from the situation under study and be meaningful to that situation. Consequently, the definition of leadership used for this study must make sense in the context of clinical staff nursing. Starting with the broad definition that leadership is a process where a nurse influences the actions of others in goal determination and achievement (Yura, 1984), the following definition is used for this study: Clinical leadership is behavior by a staff nurse that results in the delivery of quality client care.
In the leadership process, the nurse influences clients, families or other health care workers to achieve goals that develop from clinical activity or needs.

Using this definition, competency in practice skills may be an important correlate of clinical leadership, but is not in itself leadership. To illustrate, technical competency may be demonstrated by the nurse’s ability to change an intravenous tubing, administer a medication, or review the signs and symptoms of a heart attack with an at-risk patient. However, clinical leadership comes into being as the nurse purposefully moves to integrate these clinical skills with the needs of others through use of the nursing process. This process, incorporating assessment, diagnoses, goal setting, intervention, and evaluation, is done in collaboration with the client, family, organization, or community.

In summary, clinical leadership meets the two factors that are common to most definitions of leadership. It is a function of two or more people and it involves intentionally exercising influence on the behavior of other people (Owens, 1991). In addition, it does this in such a way that the quality of client care is enhanced.

Few research studies have been done that link staff nurses and leadership; two have been identified that relate directly to this study. The first, by Roe (1989), is a doctoral dissertation, focusing completely on the staff nurse and is entitled: Factors Influencing the Leadership Behaviors of Staff Nurses. Using the Leadership Behavior Description Questionnaire (LBDQ) in addition to other measures, the researcher sent out 2,324 surveys to registered full-time hospital staff nurses. Only 287 staff nurses responded. This study is severely limited by volunteer bias, low return rate, and limitations of the leadership instrumentation. Of this latter concern, the author notes that staff nurse leadership behaviors may not occur in the manner measured by the study. She notes that staff nurses may demonstrate leadership
behaviors in ways related only to delivering client care, an area which was not incorporated into the study. The author's conclusion that "staff nurses . . . are generally not demonstrating leadership behaviors" seems unwarranted in light of the study's limits.

The second study with staff nurses as a major segment of the sample was completed by McDaniel and Stumpf (1993) to look at organizational culture and key variables that affect this concept. Using a cross-sectional correlational analysis, seven acute care hospitals from Western Pennsylvania provided a pool of staff nurses from which 209 nurses responded, including 45 managers and 164 staff nurses. The Organizational Culture Inventory was used to measure culture while the Multifactor Leadership Questionnaire was used for leadership. According to these researchers, both instruments have support for reliability and validity. Demographic information was obtained by researcher developed forms. Findings indicated little inter- and intra-site variance among the seven hospitals or the groups of nurses, so that aggregate data were used for conclusions. Only the leadership level of the managers was measured. A moderate level of both transformational and transactional leadership for the head nurse was supported by the scores. Head nurses rated themselves slightly higher than did the staff nurses. Organizational culture findings for this study will be discussed under the hospital environment.

Nursing Service Environments

Overview

The National League for Nursing (1994a) notes that one of the benefits of a career in nursing is the variety of settings for practice. The League indicates that
while the majority of new nurses choose to work in acute care hospitals, other nurses practice in long-term settings, home care, educational institutions, clinics, physician offices, and as self-employed practitioners. To these, one can add a diverse group of employers that have developed from the new managed care systems such as health maintenance organizations, insurance companies, and general commercial enterprises where nurses may act as health benefit specialists. Two of the major employment settings are acute care hospitals and home care settings. These two environments were chosen for the study for this reason.

The Hospital Environment

As noted earlier, 60% of all nurses work in the acute care setting (U.S. Department of Health and Human Services, 1997). What is the hospital environment like for those registered nurses? Simply said, hospitals are cauldrons of change. Advances in technology and health science, demographic shifts, and the economics of the American health care system have given rise to major changes in hospitals and hospital nursing practice (McCloskey & Grace, 1990). Starting with prospective reimbursement in 1983, the federal government has steadily increased its control over the amount of dollars spent for the Medicare and Medicaid programs. In the later 1980s, the federal and state government were joined by private employers, who, in an attempt to control their health care costs, began to encourage use of prepaid health insurance plans. As the people who paid for health care worked to reduce expenditures, costs were shifted to the patient receiving the care, increasing their awareness of health care costs. Clinical management practices were monitored and practitioners were encouraged to move care to the least costly environment. The result was a shift toward community or home care with lower use of hospital care.
What were the results of these changes? In 1993, admissions to acute care hospitals were decreased by 11% compared to 1984, inpatient days were down by 16%, and hospital occupancy rates had fallen by 5.2% (U.S. Census Bureau, 1996). Not surprisingly, length of stay fell only 7%, which when reviewed in light of the other numbers, supported an increase in acuity of hospitalized patients that was reported anecdotally by practitioners. After initially rising to a peak in 1989, nonsupervisory payroll dollars began to drop, reflecting an increasing trend towards downsizing in hospitals.

According to McCloskey and Grace (1990), hospitals often began to cut back by decreasing both the support services available to nursing and other professional providers, such as pharmacy and physical therapy. Nurses were encouraged to pick up the skilled and unskilled tasks left over when the support service groups left. Coupled with the Primary Nursing movement within the profession itself, nursing practice in hospitals began to consist of all RN staffs.

As the 1990s began, pressure increased to reduce hospital costs even more. Staffing exclusively with RNs was increasingly seen as inefficient and unnecessary to quality patient care. Workplace restructuring began to spread from commercial enterprises to hospitals. In a discussion of restructuring at a Florida hospital, Smeltzer, Formella, and Beebe (1993) report that their 269-bed hospital was able to increase time RNs spent with patients while decreasing the nursing operations budget by 20%. A review of their plan shows that changes involved not only unit staff mix and staffing patterns, but also reorganizing patient flow, altering interdepartmental relationships and totally redefining the core nursing role. Current literature shows other hospitals undergoing similar types of changes (McLaughlin, Thomas, & Barter, 1995).
In addition, nursing service units in hospitals are increasingly moving to new professional models for organizing their services. Such approaches as shared governance, collaborative practice committees, and the opening of medical staff privileging to nurses are being tried throughout the country. Decentralization of nursing service organizations are the norm, while over 23% of all hospitals have collective bargaining agreements. Together, these activities demonstrate a desire on the part of nurses to be more involved in organizational activities and to increase their control over their practice and working conditions (McCloskey & Grace, 1990; NLN, 1988). Clifford (1991) suggests that this redesigning of the nurse's role leads to a major opportunity in hospital nursing practice by placing many practicing clinical nurses in pivotal leadership roles within the health care system.

A significant shift in the hospital environment has been the addition of the unlicensed assistive personnel (UAP), commonly called the patient care technician, unlicensed care technician, or patient care assistant. Barter, McLaughlin, and Thomas (1997) examined RN perceptions of changes in the role of the nurse and RN satisfaction with such assistive personnel. In addition to supporting "moderate to profound changes in the team leading role," they found that 53% of the RNs worked with two or more unlicensed staff during one shift and that RN knowledge of the UAP training was limited.

Organizational culture in hospitals has become of interest to researchers in health care just as it has for those in other corporate areas. McDaniel and Stumpf (1993), in their previously cited study, were most interested in understanding culture as an organizational component. Culture can be described as ways of thinking, behaving, and believing that a group of people have in common. Using Cooke's model, the researchers looked at three culture types: (1) constructive, (2) passive-
defensive, and (3) aggressive-defensive cultures. In the constructive culture, members are encouraged in achievement, self actualization, humanism, and affiliation activities. The two negative types of culture, passive-defensive or aggressive-defensive, are based on approval, convention, dependence and avoidance or opposition, power competition, and perfection, respectively. A randomly selected group of staff nurses, along with 56 managers from seven hospitals, completed the Organizational Culture Inventory. This instrument is a 120-item Likert scale based on 12 underlying factors, which, according to the authors, has established construct and content validity as well as reliability.

Leadership was measured using the Multifactor Leadership Questionnaire (MLQ) developed by Bass, which is based upon transformational/transactional leadership theory. Another instrument, the Work Satisfaction Scale, was used to measure attitudes about current work. The authors report established validity and an internal consistency reliability of 0.76. Two researcher-developed demographic items were also included.

In addition to the findings about leadership described earlier, profiles of organizational culture showed “moderately constructive” hospitals when the nurses gave the constructive factors mean scores of 37 out of 50, while passive-defensive factors had a mean of 26 and aggressive-defensive factors had a mean of 24. Overall work satisfaction was 2.9 on a scale of 5.0 with retention of nurses moderately high at 3.4 and a willingness to recommend the hospital to other nurses at 3.5. When the scores for the 12 factors were compared to the “ideal” organizational culture, the authors indicated the findings supported “relatively weak” cultures within the hospitals. They believe that in weak cultures, nurses are unclear about organizational
values and/or have a limited sense of shared expectations. Security needs and task orientation are high in this group.

Constructive culture was found to be related to several nursing service features. Moderate correlations were found between constructive culture and transformational leadership ($r = .37, p = .001$) and constructive culture and work satisfaction ($r = .35, p = .001$). A low correlation was found between constructive culture and transactional leadership. In passive and aggressive cultures, low or moderate negative correlations were found with transformational leadership ($r = -.20, p = .01$) and work satisfaction (for passive, $r = -.02, p = .001$; for aggressive, $r = -.25, p = .001$). Work support, overall satisfaction, and fitting in had negative correlations with passive or aggressive types. Thus, more negative aspects of hospital culture, such as low overall satisfaction, were more apt to occur along with aggressive or passive cultures rather than with constructive cultures.

In addition to these issues, of interest for this study is the finding that there was little inter- and intra-site variation among the hospitals and nurses, although the sample hospitals were mixed in size (three small and four large) and affiliation (incorporating academic, nonacademic, and varied religious) groups. While the study is limited by the convenience sample, the researcher’s interpretations are not dissimilar from a study of staff nurse empowerment by Havens and Mill (1992).

The changes in hospital nursing have led to major dissatisfaction for the registered nurse. Joel (1990) relates this problem to the fragmentation of practice associated with the changes and the loss of control over plans of patient care. She feels that the patient closeness and the holistic nature of nursing has been “seriously compromised by attempts to accommodate more profoundly ill patients, technology, specialization, and rapid discharge” (p. 179).
In general, RN satisfaction with unlicensed assistive personnel has not been positive. One survey study (Barter, McLaughlin, & Thomas, 1997) found only 11% of the 171 nurses “very satisfied” with UAPs, while 19% were “satisfied,” 37% were “somewhat satisfied,” 14% were “barely satisfied,” and 19% were “not satisfied.” Specifically, RN dissatisfaction centered around the UAP’s ability to communicate patient information, perform delegated tasks, and provide the RN with more time for professional nursing activities.

Increasingly nurses, through their professional organizations and in individual interactions, are voicing their concerns over the changes occurring in nursing practice (Burtt, 1997; Shindul-Rothschild, Berry, & Long-Middleton, 1996). Reporting on a survey completed for the *American Journal of Nursing* in 1996, Shindul-Rothschild, Berry, and Long-Middleton note that nurses are expected to work harder, faster, and with less resources. As a result, two out of five nurses report increases in patient complications, medication errors, nosocomial infections, skin breakdown, and injuries to patients. Thirty-seven percent would not recommend that a family member receive care in their hospitals. The survey response totaled 7,000 nurses with respondents representative of the national RN population for all demographic characteristics and key variables of acute care hospital settings and medical surgical specialties. The margin of error was reported as less than 1 percent.

Throughout the country, the American Nurses Association has reported increasing problems not only with patient care but for nurse’s personal health and welfare (Burtt, 1997). Fewer staff leads to mandatory overtime, which increases nurse fatigue and can lead to burnout or other personal problems. Additionally, nurses have 65% more work-related injuries in institutions where nursing staff is reduced. Finally, legal concerns develop as more activities are delegated to
unprepared assistive staff or nurses are forced to work in specialities outside of their area of expertise. The acute care hospital environment is not an easy place to practice professional nursing today, nor will it be for several years to come, given the current process of change.

The Home Care Environment

The provision of illness related care in the home has been a feature of society throughout the ages. Modern home health care in the United States can be traced back to its roots in the early 20th century with the development of private duty and public health nursing. Although time has greatly altered the scope and extent of home care services, the twin goals of providing nursing services to those in the home and education of patients and families remain unchanged (Dieckmann, 1988). As defined by the National Association for Home Care, home care is:

Services to the recovering, disabled, or chronically ill person providing for treatment and/or effective functioning in the home environment. Home care can also assist in the provision of services to adults and children in danger of abuse or neglect. Generally home care is appropriate whenever a person needs assistance that cannot be easily or effectively provided only by family members or friends on an ongoing basis for a short or long period of time. (Rice, 1996, p. 3)

A variety of agencies provide home health services. In the last 10 years, both the type and number of such groups have changed, with the increase in demand for cost-effective noninstitutional health care. Agencies are categorized by sponsoring organization. In 1992, there were 6,129 Medicare certified home health agencies in the United States. Forty percent of these were sponsored by community based for profit and private nonprofit agencies. Hospital-based programs accounted for another 30%. Visiting Nurse Services (VNAs), agencies associated with a national organization, accounted for 10%. Public Health Agencies, usually a part of the local
Department of Public Health, accounted for 19%. The change in the type of agencies can be demonstrated with a comparison with 1967 figures, where 1,753 agencies existed with VNAs and public agencies represented 90% of the total and the remaining 10% was split between the other groups (Richardson, 1995).

Dieckmann (1988) reports that this extensive growth is the result of several factors. Over this century the nature of disease has changed from infectious processes with acute episodes to chronic conditions lasting for long periods of time. Additionally, the demographic shift from a younger to an older population occurring now and continuing for the near future means that more individuals are in the higher age brackets where extensive health care is needed. The loss of the multigenerational households and the need for two family income have also contributed since there are fewer available family members to provide health care on their own. Many people prefer care at home and feel it improves their quality of life. Lastly, reimbursement is a key factor. Reimbursement for hospital care limits length of stay to acute states with discharge to home care with the expectation that cost will be reduced in that environment. Thus, home care clients require more visits since acuity has increased. Reimbursement itself has allowed the home care field to be financially profitable. Prior to Medicare funding in the mid sixties, home care was often a charitable venture.

While much change has already occurred in home care, a synthesis of past and emerging trends would suggest that more change can be expected (Halamandaris, 1988). There is concern about the recent increases in costs, especially relative to quality of care and the ever increasing demand for services. These important factors make research of home care settings more critical and relevant to the practice of nursing.
In home care, the staff nurse plays a major role in the care a client receives from the agency. The staff nurse often serves as the coordinator of the total care. Working with the physician, client, family members, other disciplines and various community agencies, the staff nurse ensures that needed services are provided efficiently and effectively (Humphrey & Milone-Nuzzo, 1996).

Current research in home health care focuses on clinical or reimbursement issues. Little literature focused on the environment of home care agencies; none was found that looked at the nonclinical skills needed by home care nurses. This situation is in contrast to this author's private discussions with home care executives who express concern about the effect of the changes going on in the field which require additional nonclinical skills.

As hospital staffing requirements decrease, more nurses look toward home care agencies as a source of employment. Yet, the two settings are quite different. Kraus (1994) worked with seven regional home care managers to identify key stressors for new employees coming from the hospital environment. For the staff nurse, these include (a) care provided in the patient's territory; (b) a more typical business setting with a greater emphasis on economic recovery of nursing dollars versus the "nonprofit" hospital; (c) increased independence with a decrease in peer contact and support; (d) responsibility not only for direct care but also for educating patients in providing their own care; (e) responsibility for making decisions without direct patient contact when the nurse is the supervisor for a geographic area with other staff as the direct provider of care. These stressors may be addressed with initial orientation programs, ongoing staff development, and educational coalitions with both employment settings and universities (Kraus, 1994; Humphrey & Milone-Nuzzo, 1996; O'Neill & Pennington, 1996).
Some idea of how the staff nurse perceives the home care working environment may be extrapolated from a study comparing the work environment perceptions of home health aides and staff nurses (Dutcher & Adams, 1994). The instrument used was Moo’s Work Environment Scale (WES), which is composed of a relationship dimension, a personal growth dimension, and system maintenance and system change dimensions. This scale, in an earlier study of 1,607 employees from a variety of healthcare settings, had internal consistency values of 0.69 to 0.86, a 1-month subscale test-retest reliability of 0.69 to 0.83, and 12-month values of .51 to .63. In this study, the researcher found that staff nurses were pleased with their work environment, perceived management as supportive, found the press of work to be high, emphasized a task orientation, and found time organization and planning important. When asked to list reasons for staying at their agency, staff nurses reported liking the independence, autonomy, and flexible work schedules. The home care staff nurses’ scores were higher than those of the health care workers in the earlier group except for the subscale of control, which was lower. While the authors did not suggest a reason for this finding, as with the work pressure interpretation, the lower control might be attributed to the changes in patient’s status and other complexities of the staff nurse position.

Summary and Hypothesis

Even though leadership may be defined in a variety of ways, the transformational model of leadership seems well suited to nursing during this period of development in the profession, and yet its applicability to the clinical setting needs to be assessed using research methods. Incorporating a transactional component along with the transformational model allows for description of a variety of
leadership behaviors on the part of staff nurses. Given the limits of the research on staff nurses, using a transactional/transformational approach is logical. While followership has often been described in passive terms, newer models focus on a more active form, avoiding the negative perspectives of the past. Kelley's followership model, including independent thinking and active engagement, is currently the most coherent framework for this newer trend. At one time, leadership and followership were seen as opposites or mutually exclusive traits; one was either a follower or a leader. The newer conceptualizations suggest the two constructs be seen as related traits where at one time a person may be a follower and another time, a leader. Performing both roles well is a key element in success for the nursing profession and is necessary at all levels (DiRienzo, 1994).

Currently, the majority of staff nurses work either in the hospital or in home care agencies. These two environments also represent both the past and the future with hospitals cutting back from their previous dominant position, to home care agencies, which are projected to continue their growth of recent years, although at a slower rate. However, these two environments are not the same; each has its own cultures, demand, and approach. Considering the differences identified in the literature between the hospital and home care environments, it is logical to propose that the behaviors used in leadership and followership may well be different between the two settings. Given that, the primary purpose of this study is to test the following research hypothesis: Staff nurses in the hospital environment will use different leadership and followership behaviors than staff nurses in the home care environment.

Little empirical study has been done on leadership and followership in staff nurses. Yet, the staff nurse is the main provider of direct patient care in a profession where clinical practice has always been the core activity (Fralic, 1993). It is the
bedside nurse who leads patients, those for whom the profession exists (Rimar, 1991). Coupled with the newer conceptualizations of followership, these points support the need for further research into the behaviors of the staff nurse. Inherently part of the hypothesis already stated, this study will also describe the leadership and followership behaviors used by staff nurses.

Additionally, the review of the literature has led to a variety of other factors that may influence the use of leadership and followership behaviors. Educational background has been a key issue for the nursing profession. Studies that have looked at the effect of education on leadership have had mixed results, yet nursing experts continue to suggest that formal education is a key factor in developing leadership behavior regardless of setting. New responsibilities in delegating care and for patient care coordination, requiring extra interaction with other members of the health care team, have been added to the previous charge nurse activities carried out by many hospital staff nurses. With these activities, staff nurses influence both more patients and patient care activities without necessarily providing direct patient care. This suggests a potential for greater use of leadership behaviors. Conversely, a lack of such opportunity, measured as greater frequency of direct care time, decreases the chance for such behavior. As part of the secondary purpose, the study will explore the effect these factors may have on nurses' leadership and followership behaviors as an explanatory alternative to the findings on setting.

Analysis and interpretation of findings relative to these objectives will be of value to the clinician, the administrator, and the educator. As many nurses begin the process of changing work environments, knowledge of needed skills may provide a means of self and/or supervisory assessment. It is expensive to orient staff to either home care or hospital settings; any information that may lead to a better employee-
employer match can save dollars. Additionally, the new information can be used by educators in the basic programs and in staff development.
CHAPTER III

METHOD

This study hypothesizes that staff nurses in different employment settings will use different leadership and followership behaviors. While the literature review demonstrates that little attention has been given to measuring such behaviors in the staff nurse, a conceptual basis for their presence has been laid. Transformational Leadership by Bass and the Kelley followership model provide the conceptual framework for the investigation. The literature also suggests that certain key characteristics, such as educational background, may influence the quantity and type of behaviors used. Measuring and analyzing these characteristics will add breadth to the knowledge gained on the behaviors used. This chapter describes the population, sample, and instrumentation used. Procedures for analyzing the data to meet study objectives are also presented.

Population and Subgroups

Determining the Population

The target population for this study consists of staff nurses working in hospital and home care settings in the United States that are engaged in a variety of focused clinical activities with patient care as their primary role. The accessible population consisted of nurses employed by a corporate entity in the Midwest. The corporation is a not-for-profit aggregate of hospitals and affiliated home care
agencies owned by a religious organization and incorporated in two Midwestern states. A corporate entity was chosen because it was felt it would generate a sample with a common organizational approach while allowing for description of the differences in variables related to the staff nurses and controlling for variables related to size. While this corporate group had a religious affiliation, there is no documentation that this affiliation would have an effect on staff nurses or the variables of leadership and followership. In general, the effect of religious affiliation on hospital personnel issues would be secondary or indirect since the agencies are run by lay community boards and have administrative staff separate from the religious institution.

**Determining the Agencies or Subgroups**

The corporate system is composed of 15 hospitals and associated home care agencies. Initially, four hospitals, with 300 to 500 occupied beds, were chosen to be in the study to maintain consistency of size. The four corresponding home care agencies were chosen as the source of home care nurses.

The factor of size of agency was a consideration. There is a potential for varying staff nurse roles in different sized agencies. Larger organizations are more apt to have a variety of specialized roles that may serve as resources to staff nurses, whereas in smaller agencies these may be lacking. The investigator's personal experience has led to the observation that nurses in a very small hospitals often have competencies in multiple clinical areas, serving on the obstetric unit one day and functioning in the emergency room the next. Also, nurses may have developed more extensive leadership behaviors due to lack of other human resources. As size
increases, these effects would occur less frequently, allowing the nurse to focus on a particular area or using the expertise of others.

Size is often related to urban versus rural placement. Organizations found in major cities and in academic environments have resources that are not available elsewhere. Smaller organizations, on the other hand, often found in rural areas, have different assets and liabilities which may affect the nurses under study. Such factors as educational opportunities, unionization, and financial reimbursement come to mind as possible examples. These reasons supported limiting the hospitals to those of a medium size. The hospital and its associated home care agencies were paired as an additional control of state regulations, administration, and other variables.

After contacting the Director of Nursing, one hospital refused to participate and it was dropped along with its corresponding home care agency. A replacement was added which was located in a second state. After data collection had begun on the first two agency pairs, it was noted that home and hospital identification information was not placed on the survey and, thus, the agency type could not be determined. Consequently, data from two of the pairs were unusable and they were dropped from the study. At that point, the list was reviewed and the largest hospital with over 700 beds and seven small hospitals of under 100 beds were eliminated due to size considerations. The remaining two agencies were contacted for inclusion in the study. In the end, time constraints led to ending data collection before access to nurses in the last hospital/home care dyad was arranged. The sample consisted of data from six subgroups, three hospitals, and three home care agencies from two states. Occupied bed size for the hospitals ranged from 155 to 425; days per visit for the home care agencies were from 50,000 to 100,000 visits per year. The agencies or subgroups providing the nurses thus were not a representative sample of the
corporate entity or of a national population. The subgroupings, although all could be considered medium size, did have a range in hospital bed size of 270 and a range of 50,000 in visits per year for the home care agencies. None of the subgroups were directly run by academic institutions, although all maintained some affiliation with 4-year programs for clinical placement.

Selection of the Sample Within the Subgroups

Procedural Aspects

After obtaining acceptance from the corporate offices, a key nurse administrator was approached in each agency. When the agency’s willingness to participate was ascertained, approval from the Western Michigan University Human Subjects Institutional Review Board was sought and granted (Appendix B) and the necessary committee approvals from each agency were obtained as needed.

The number of subjects to be drawn was determined proportionally for each agency based on the desired sample size of 150 nurses in the hospital subgroup and with a matching 150 nurses from the home care subgroup. Using a list of employed staff nurses from each agency, the staff nurses were randomly selected using assigned code numbers to allow for follow-up. All nurses were on full- or part-time status and on-call staff were excluded.1 Surveys were distributed to 238 nurses in three hospitals and three home care agencies using this random proportional selection process.

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1 On-call staff are nurses who work less frequently than one weekend per month.
To encourage responses, the survey packet included a packet of cocoa with an invitation to the staff nurse to enjoy a cup of cocoa while they completed the forms. Follow-up was done for each agency with the distribution of a thank you note or a new survey packet for each nurse, and a reminder placed either on the electronic mail system or via a posted flyer. A total of 136 surveys were returned for a 57% return rate.

Consideration of Return Rate

The response by agency had a high variance; rates ranged from a low of 29% to a high of 84%. When viewed by Hospital and Home Care Groups, the rates were 58% and 57%, respectively. Ranking of the rates were the same for associated agencies, the paired hospital/home care unit. After a follow-up response rate of 21% was obtained from one agency, the researcher talked with the cooperating manager. After this discussion, two possible influencing situations specific to this agency were identified: these surveys had been distributed by being mailed to the nurses' homes rather than by placement in on-unit mailboxes, and the cooperating manager was in the personnel area versus being within the nursing hierarchy as was the case in the other agencies. Also of possible importance is that the low response pair had undergone an unexpected structural integration in the preceding 6 months, while the other two pairs were in the process of a planned structural integration but were not yet finished. (This integration involves combining the hospital and home care agencies' organizational structure under one hierarchy versus maintaining separate subsidiaries for acute and home care.) At the request of the researcher, the cooperating manager distributed a second set of replacement surveys and a final response rate of 29% was obtained.
Instruments

The data collection instrument for this study consisted of a questionnaire that had three parts: a general information section for demographic and organizational factors developed by this researcher, a section consisting of the Multifactor Leadership Questionnaire, and the final section consisting of the Followership Survey by Robert Kelley (1992). Appendix C provides a copy of the complete questionnaire.

General Information Section

This section includes general demographic information and information that has been identified through the review of the literature as relevant to the topic area of staff nurses and leadership. Factors that had been identified as affecting the study include: (a) respondent characteristics such as age, years of experience, years in this agency, initial educational preparation, highest educational degree, and certification status; and (b) factors related to the organization, including presence of auxiliary workers and frequency of charge nurse experience.

Leadership Behaviors

The instrument selected for measurement of leadership behaviors was the Multifactor Leadership Questionnaire (MLQ), Form 5x-Short. This version of the MLQ is the latest version in use for research. The MLQ was developed by Bernard M. Bass and Bruce J. Avolio and published in 1990. It was designed to "capture the broadest range of leadership behaviors while differentiating ineffective from effective leaders" (Bass & Avolio, 1995, p. 4). The scale has 48 items and is a measure of eight factors for the types of leadership, one factor for nonleadership, and three
factors listed by the authors as “criterion outcomes.” The specific subscales are: Idealized Influence (Attributed), Idealized Influence (Behavioral), Inspirational Motivation, Intellectual Stimulation, Individual Consideration, Contingent Reward, Management by Exception (Active), and Management by Exception (Passive), with Laissez-Faire as Nonleadership. Effectiveness, Satisfaction, and Extra Effort are the criterion outcomes. The approximate time for this instrument’s completion is 15 minutes.

Development of the MLQ occurred over a period of several studies in the middle to late 1980s. A pilot study was done to see if the concepts of transactional (TA) and transformational (TF) leadership made sense in modern organizations by surveying 70 industrial executives. The researchers interpreted the findings to be consistent with their theory, although several additional concepts were identified as significant. Overall, Bass believed the pilot study supported the importance of the concept in today’s workplace.

Several studies were carried out to quantitatively differentiate the two styles of TA and TF leadership using an instrument that was reliable and valid. Behaviors were first reviewed by definition and along with the pilot data and a literature review, 142 potential items were developed. After review and categorization, 73 were included in the final tool. Further testing compared the subscales to the Stodgdill Leadership Behavior Description (LBDQ), confirmed factors/subscales with factor analysis, and addressed reliability issues. After these efforts, Bass concluded that the tool had acceptable reliability and validity.

This conclusion did not go unchallenged by other leadership researchers. Several authors have criticized the MLQ and related research citing concerns of discriminant validity with the high intercorrelations found between factors, the
inclusion of behavioral and impact items in the same instrument and inability to replicate the initial factor structure proposed by Bass (Hunt, 1991; Smith & Peterson, 1988; and Yukl, 1989, 1994). Bass and Avolio (1995) responded by maintaining that while the original structure of Transformational, Transactional and Laissez-faire remains conceptually sound, current evidence suggests that the structure is much more complex than originally thought. Consequently, they began further work to refine the instrumentation. Form 5X-Short and Form 5X-Long are the results of this refinement.

Items for Form 5X-Short were selected through (a) factor analysis and partial least squares analysis using data from earlier forms, and (b) developing new items or modifying old items based on literature and input from other scholars. The revisions led to renaming and separating the factor of Charisma into two factors, one each for behavior and impact; these are referred to as “Idealized Influence (Behavior)” and “Idealized Influence (Attributed).”

The Technical Report (Bass & Avolio, 1995) accompanying the Form 5X-Short provides some results of the preliminary work. Using nine samples of various independent research studies, Bass and Avolio found that “all of the scales’ reliabilities were generally high,” values ranged from .74 to .94, and that reliabilities within each data set generally indicated that the MLQ 5X was “reliably measuring each of the leadership factors across the nine data sets” (p. 9). For the total items and for each leadership factor scale, the alpha values ranged from .74 to .94. The researchers note that these preliminary results support the use of the Form 5X-Short for measuring a broader range of leadership factors across different cultures and settings. As noted in Chapter II, the MLQ has been used with nurses in formal management positions but not specifically with staff nurses.
Followership Questionnaire

As mentioned in Chapter I, the concept of followership has not been studied to the same extent as leadership. If anything, the role of the follower has been largely ignored. Few instruments are accessible and those that are available are comparatively weak in evidence to support reliability and validity when compared to leadership instrumentation. A review of the literature on followership suggested that adding this element might provide some pieces missing from studies on leadership in clinical nursing areas. The instrument used in this study is the Followership Questionnaire (FQ) developed by Robert Kelley (1992).

A 20-item questionnaire, the FQ uses a 7-point Likert scale from 0 to 6 with 0 being “rarely,” 3 “occasionally,” and 6 “almost always.” The instrument purports to have two purposes: to help people determine the kind of follower they are, and to pinpoint strengths and areas for improvement. According to Kelley (1992), the concept of followership has two dimensions: Thinking, subdivided into independence and critical; and Engagement, active or passive. Scoring the questionnaire allows the respondent to be placed on a graph on two axes representing the dimensions. A high Thinking scale score indicates independence in thought and critical thinking. A high Engagement score means active engagement. Five followership styles, detailed in Table 1, can be described.

The FQ was developed in the early 1990s by Kelley out of his academic work at Carnegie Mellon University where he holds the title of Adjunct Professor of Business in the Graduate School of Industrial Management. In addition, as a consultant, Kelley has worked with national organizations, businesses, and other groups. Kelley’s research involved surveys of over 700 individuals who responded
with their views on leadership and followership. Survey respondents were an average of 37 years old with 13 years of work experience under a variety of different managers and companies. Over 20 industries were represented in the results (Kelley, 1992).

Table 1

<table>
<thead>
<tr>
<th>Followership Style</th>
<th>Independent Thinking Score</th>
<th>Active Engagement Score</th>
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</thead>
<tbody>
<tr>
<td>Exemplary</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Alienated</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Conformist</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Pragmatist</td>
<td>Middle</td>
<td>Middle</td>
</tr>
<tr>
<td>Passive</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

Evidence of reliability and validity of the scale is limited. According to Kelley (personal communication, 1994), prior effort in that direction has been minimal. However, the instrument has had increasing use in the past several years. This limited evidence is not surprising given the current state of empirical research on followership.

Only two competing instruments were identified. One, by Frew (1977), relates followership style to the more passive perspective. That is, followership is dependent on the leader and one's followership style is based on the type of leader preferred. This instrument was rejected as inconsistent with the active definition of followership projected for this study. The second instrument available was developed by Gilbert (Gilbert & Whiteside, 1988). This instrument was rejected due to lack of
clarity as to the nature of followership being assessed and its development from police work, a profession with a philosophical and conceptual basis quite different than nursing. Neither competitive instrument had commanding evidence for reliability and validity.

Data Considerations and Treatment

Of the 238 questionnaires distributed, 136 were returned for a 57% return rate. Questionnaires were reviewed for completeness; data were edited and coded by the researcher and entered into a spreadsheet for data analysis. Initial review identified a concern regarding missing data and further analysis was done. Only minimal data were missing for the Followership portion of the survey and analysis proceeded with the 136 questionnaires. However, a larger problem was noted for the Multifactor Leadership Questionnaire (MLQ) where it appeared that the questions were confusing for the nurses. Both the Hospital and Home Care Groups were missing similar amounts of data. Table 2 shows the valid number of responses available from the MLQ subscales for the hospital and home care subgroups individually and together. In the combined figures, the portion of the MLQ that had the most missing data was the subscale of Contingent Reward. The specific items for Contingent Reward relate to giving something in return for effort. The next lowest factor had 50% less data missing. The least missed items were in the subscales of Laissez-faire and Management by Exception-Passive. In some cases, a note was written on the returned survey indicating that the respondent was unsure of how to respond, or a NA (not applicable) was included. However, the majority did not indicate anything other than a blank spot.
Table 2

Number of Responses and Percent of Responses for the MLQ Subscales

<table>
<thead>
<tr>
<th>MLQ Subscale</th>
<th>Hospital 69</th>
<th>Home Care 67</th>
<th>Total Group 136</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Valid n</td>
<td>%</td>
<td>Valid n</td>
</tr>
<tr>
<td>Idealized Infl.–Attributed</td>
<td>65</td>
<td>94%</td>
<td>62</td>
</tr>
<tr>
<td>Idealized Infl.–Behavior</td>
<td>66</td>
<td>96%</td>
<td>62</td>
</tr>
<tr>
<td>Inspirational Motivation</td>
<td>65</td>
<td>94%</td>
<td>62</td>
</tr>
<tr>
<td>Intellectual Stimulation</td>
<td>66</td>
<td>96%</td>
<td>62</td>
</tr>
<tr>
<td>Individual Consideration</td>
<td>66</td>
<td>96%</td>
<td>62</td>
</tr>
<tr>
<td>Contingent Reward</td>
<td>64</td>
<td>93%</td>
<td>61</td>
</tr>
<tr>
<td>Laissez-faire</td>
<td>67</td>
<td>98%</td>
<td>62</td>
</tr>
</tbody>
</table>

The MLQ data were analyzed after eliminating those with significant missing data in the following manner. First, the seven questionnaires that were missing all items were eliminated. For the remaining data, subscales were not computed if more than 2 out of 4 items were missing, maximizing the valid number available for more detailed analysis. Consideration of loss of data, consistency between Hospital and Home Care Groups missing responses, and the early nature of the study supported this approach.

Analysis of the Data

The primary purpose of this study is to test the hypothesis that setting affects leadership and followership behaviors. The hypothesis was operationalized to mean that nurses in hospital settings would have mean scores on at least one of the leadership dimensions and one of the followership dimensions that were different than
nurses in home care settings with the alpha set at 0.05. This hypothesis was tested using the $t$ test for independent means to compare the mean scores between the hospital and home care nurses that were obtained on the seven Leadership and two Followership subscales.

To meet the secondary purpose of the study, exploring leadership and followership behaviors used by staff nurses, several other data approaches were undertaken. First, respondents in both groups were described for age, education, years of nursing experience, charge nurse frequency, and involvement in direct care, using frequencies and percents. This was meant to provide a means of comparing the sample to other groups. Next, the key characteristics were used as categorizing groups allowing supplementary data analysis to evaluate possible alternative explanations for the results of the hypothesis testing. For example, the basic educational program data were used to decide if initial levels of education were different for hospital and home care nurses which might explain any differences found in leadership and followership behaviors.

Additionally, results of the MLQ provide information on the specific leadership behaviors used. These are described and followership scores charted to identify the specific styles used by the staff nurses.

Assessment of the quality of instrumentation was the last goal of data analysis. Cronbach's Alpha was used to determine the reliability coefficient for both instruments. However, since these instruments had not been used with this population, a number of correlations were also computed for comparison with the data presented in the MLQ Technical Report. These included intercorrelations between the subscales of the MLQ, between the MLQ items and the criterion items, and between the MLQ and the Followership subscales. If the correlations were
consistent between this sample and other reported samples, additional evidence of the
quality of instrument measurement would be garnered. Chapter IV will detail these
findings.
CHAPTER IV

FINDINGS

One hundred and thirty-six surveys were returned and subjected to data analysis as described in Chapter III. In this chapter the findings from these surveys are presented. First, respondent characteristics are described to provide a context for review of the other findings. Next, analysis related to the instrumentation will be discussed. Thirdly, the results of the hypothesis testing will be presented. The specific types of leadership behaviors identified by the staff nurses will be given, along with the styles of followership used. Lastly, the relationships between the key characteristics, identified as potential influences in the literature, and leadership/followership behaviors will be presented to complete the exploration of how leadership and followership in staff nurses was measured by the tools used.

Respondent Characteristics

Compared to National Figures

Table 3 provides a comparison of this sample and national figures for age and education. In general, the sample was comparable to a national pool of RNs in age with an average age of 42.3 years (U.S. Department of Health and Human Services, 1994). In the sample, both the initial education and the highest educational level obtained vary from that found at the national level. Fewer sample nurses were from the Diploma program, while proportionally there were greater numbers of ADN and
BSN nurses than in the national pool. In this sample, 23% of the nurses went on for a higher degree.

Table 3
Sample Age and Education Compared to National Groups

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Samplea</th>
<th>National Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Years</td>
<td>n</td>
</tr>
<tr>
<td>Average Age</td>
<td>39.37</td>
<td></td>
</tr>
<tr>
<td>Initial Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>22</td>
<td>16.2</td>
</tr>
<tr>
<td>ADN</td>
<td>76</td>
<td>55.9</td>
</tr>
<tr>
<td>BSN</td>
<td>38</td>
<td>27.9</td>
</tr>
<tr>
<td>Highest education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>12</td>
<td>8.8</td>
</tr>
<tr>
<td>ADN</td>
<td>65</td>
<td>47.8</td>
</tr>
<tr>
<td>BSN</td>
<td>51</td>
<td>37.5</td>
</tr>
</tbody>
</table>

Note. Eight reported Bachelor degrees other than the BSN or graduate degrees as their highest education.

a n = 136.

Sample Hospital and Home Care Comparison

Several differences were found between the hospital and home care respondents in the demographic variables. These are listed in Table 4 and include, specifically, the number of years at the employing agency, frequency of charge nurse experience, and the amount of time spent in direct care. Hospital nurses had an
Table 4
Respondent Characteristics for Hospital and Home Care Groups

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Hospital Nurses&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Home Nurses&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Years in nursing</td>
<td>13.39</td>
<td>9.42</td>
</tr>
<tr>
<td>Years at agency&lt;sup&gt;***&lt;/sup&gt;</td>
<td>10.63</td>
<td>8.29</td>
</tr>
<tr>
<td>Charge nurse role&lt;sup&gt;**&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>Less than 1/wk</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>1–2/wk</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td>More than 2/wk</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Amount of direct care&lt;sup&gt;***&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–25%</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26–50%</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>51–75%</td>
<td>16</td>
<td>24</td>
</tr>
<tr>
<td>76–100%</td>
<td>45</td>
<td>66</td>
</tr>
<tr>
<td>Work both&lt;sup&gt;***&lt;/sup&gt;</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>Delegation</td>
<td>63</td>
<td>91</td>
</tr>
<tr>
<td>Certified</td>
<td>16</td>
<td>25</td>
</tr>
</tbody>
</table>

<sup>a</sup><sub>n = 69</sub>. <sup>b</sup><sub>n = 67</sub>.  
**<sup>p < .01</sup>.  ***<sup>p = .000</sup>.

average of 10.6 years at the agency compared to 4.4 years for the home care nurse group (<sup>p < .000</sup>). This difference is understandable when the relatively recent growth of the home care setting is taken into consideration. Next, 36% of the hospital nurses took charge one or more times per week, while only 19% of the home care nurses reported that frequency; 39% and 63%, respectively, indicated they never take charge.
(p = .01). While home care nurses did not take charge as frequently, they still
generated less direct care than the hospital nurses (p < .000), probably due to the
amount of care coordination required in that setting.

Nationally, about 16% of registered nurses held other paid nursing positions
in addition to their principal nursing position (Department of Health and Human Services, 1994). Thus, it is not surprising that in this sample, some respondents
worked in both hospital and home care settings. Of the total sample, 46% worked in
both settings, although over twice the proportion of nurses in the Home Care Group
(55% vs 26%) worked in both. Because of the potential impact of this factor on the
hypothesis, analysis included testing the hypothesis by splitting the data into nurses
who worked both settings and nurses who worked one setting only.

Instrument Assessment

Prior use of the MLQ had resulted in reliability coefficients of .74 to .94 for
the subscales (Bass & Avolio, 1995). Subscales reliabilities were lower in this study
ranging from .43 to .76 (see Table 5 for these figures). Only two of the leadership
subscales achieved an alpha value above .70; these were Motivation and Management
by Exception—Active.

A comparison of intercorrelations among the subscales comprising the MLQ
was made between those found in this sample and those reported in the Technical
Manual. In general, fewer correlations were found. This was especially true in the
subscales of Management by Exception—Passive, and Laissez-faire. Additionally,
those correlations that were supported were weaker in this study than in the reported
data. It is important to note that the figures quoted from the Technical Manual are for
Table 5

Subscale Reliability Coefficients

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idealized Influence–Attributed</td>
<td>.54</td>
</tr>
<tr>
<td>Idealized Influence–Behavior</td>
<td>.56</td>
</tr>
<tr>
<td>Inspirational Motivation</td>
<td>.74</td>
</tr>
<tr>
<td>Intellectual Stimulation</td>
<td>.56</td>
</tr>
<tr>
<td>Individual Consideration</td>
<td>.54</td>
</tr>
<tr>
<td>Contingent Reward</td>
<td>.45</td>
</tr>
<tr>
<td>Management by Exception–Active</td>
<td>.74</td>
</tr>
<tr>
<td>Management by Exception–Passive</td>
<td>.68</td>
</tr>
<tr>
<td>Laissez-faire</td>
<td>.64</td>
</tr>
</tbody>
</table>

ratings by others rather than for ratings for self; differences in the subscale ratings may partially be based on this difference.

Table 6 provides the correlation matrix for the MLQ, including the criterion measures of effort, effectiveness, and satisfaction.

Reliability data were unavailable for prior use of the Followership Questionnaire; for this study, the Cronbach’s Alpha was .74 for the Thinking Score, and .87 for the Engagement Score. As expected, the Independent Thinking and the Active Engagement subscales were moderately correlated ($r = .56, p < .001$).

Measurement adequacy should take into consideration the limits imposed by the nature of self-report. The nature of self-report is also a limitation for this study. No objective measurements were incorporated into the study. Response bias may come from a number of sources. For example, responses may well be different from the nurses actual behaviors if respondents feel their actual behavior is less socially
Table 6
Correlation Matrix for the Subscales of the MLQ

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Idealized Infl-A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idealized Infl-B</td>
<td>.49**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivation</td>
<td>.66**</td>
<td>.53**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Stimulation</td>
<td>.43**</td>
<td>.49**</td>
<td>.53**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Consideration</td>
<td>.51**</td>
<td>.45**</td>
<td>.55**</td>
<td>.55**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Reward</td>
<td>.55**</td>
<td>.46**</td>
<td>.58**</td>
<td>.54**</td>
<td>.38**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBE–Active</td>
<td>.28**</td>
<td>.25**</td>
<td>.29**</td>
<td>.40**</td>
<td>.18*</td>
<td>.36**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MBE–Passive</td>
<td>-.11</td>
<td>-.04</td>
<td>-.10</td>
<td>-.03</td>
<td>-.12</td>
<td>-.02</td>
<td>.25**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laissez-faire</td>
<td>-.19*</td>
<td>-.06</td>
<td>-.14</td>
<td>-.00</td>
<td>-.24**</td>
<td>-.02</td>
<td>.22*</td>
<td>.48**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effort</td>
<td>.52**</td>
<td>.36**</td>
<td>.50**</td>
<td>.42**</td>
<td>.52**</td>
<td>.50**</td>
<td>.30**</td>
<td>-.03</td>
<td>-.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectiveness</td>
<td>.61**</td>
<td>.42**</td>
<td>.60**</td>
<td>.39**</td>
<td>.47**</td>
<td>.48**</td>
<td>.27**</td>
<td>-.14</td>
<td>-.18**</td>
<td>.65**</td>
<td></td>
</tr>
<tr>
<td>Satisfaction</td>
<td>.53**</td>
<td>.33**</td>
<td>.47**</td>
<td>.38**</td>
<td>.54**</td>
<td>.41**</td>
<td>.21*</td>
<td>-.26**</td>
<td>-.18</td>
<td>.56**</td>
<td>.68**</td>
</tr>
</tbody>
</table>

*p < .05.  **p < .01.
acceptable. Since the survey was distributed in the work setting, the respondents might well have chosen responses based on how they wanted others to see them, rather than as they actually were. Many researchers have considered social desirability to be a major factor in measurement error (Walz, Strickland, & Lenz, 1991). The forced choice format, anonymity and confidentiality, and other measures detailed under the methodology section were used to reduce this possibility, but it cannot be totally eliminated.

Testing the Hypothesis: Does Setting Make a Difference?

The hypothesis for the study, staff nurses in the hospital environment will use different leadership and followership behaviors than staff nurses in the home care environment, was tested using $t$ tests for independent means. No difference was found for any of the factors of the MLQ or the Followership scores of Independent Thinking and Active Engagement. Table 7 presents the results of this testing with the total sample of nurses. Note that hospital and home care groups were mutually exclusive with each respondent belonging to only one or the other group.

As noted earlier, a certain number of the staff nurses worked both hospital and home care settings. Fully 55% (36 individuals) of the Home Care Group and 26% (18 individuals) in the Hospital Group were also employed in the alternative setting. Since this finding was not anticipated at the start of the study, the hypothesis was further explored by eliminating these individuals and looking solely at a “pure” sample of hospital ($n = 51$) and home care nurses ($n = 30$). Since some of the subscales could not be computed due to missing data, group size varied for each individual subscale. Table 8 shows the results of this testing. Again, no difference was found.
Table 7

Results of *t* tests for Leadership and Followership Using Total Sample

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Hospital Nurses</th>
<th>Home Care Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>MLQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idealized Influence (A)</td>
<td>2.90</td>
<td>.48</td>
</tr>
<tr>
<td>Idealized Influence (B)</td>
<td>2.81</td>
<td>.53</td>
</tr>
<tr>
<td>Inspirational Motivation</td>
<td>2.83</td>
<td>.52</td>
</tr>
<tr>
<td>Intellectual Stimulation</td>
<td>2.77</td>
<td>.52</td>
</tr>
<tr>
<td>Ind. Consideration</td>
<td>3.16</td>
<td>.47</td>
</tr>
<tr>
<td>Contingent Reward</td>
<td>2.98</td>
<td>.52</td>
</tr>
<tr>
<td>Mgmt-by-Exception (A)</td>
<td>1.57</td>
<td>.90</td>
</tr>
<tr>
<td>Mgmt-by-Exception (P)</td>
<td>1.06</td>
<td>.71</td>
</tr>
<tr>
<td>Laissez-faire</td>
<td>.88</td>
<td>.72</td>
</tr>
<tr>
<td>Followership Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ind. Thinking</td>
<td>40.47</td>
<td>7.50</td>
</tr>
<tr>
<td>Active Engagement</td>
<td>44.29</td>
<td>6.85</td>
</tr>
</tbody>
</table>

Two additional possibilities were tested; one covered whether nurses working both settings reported different behaviors, and the second, whether behaviors differed between the hospital and home care dyad. The dyads were included to provide consideration of geography since both the hospital and the paired home care agency were in the same city. No difference was found for either possibility.

**Description of the Leadership Behaviors Used**

On the 5-point scale of 0 to 4 used by the MLQ, mean scores for the groups ranged from .72 for the Laissez-faire score to a high of 3.28 for Individual...
Table 8
Results of t tests for Leadership and Followership—Nurses Working One Setting Only

<table>
<thead>
<tr>
<th>Subscales</th>
<th>Hospital Nurses</th>
<th>Home Care Nurses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>MLQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idealized Influence (A)</td>
<td>2.88</td>
<td>.57</td>
</tr>
<tr>
<td>Idealized Influence (B)</td>
<td>2.66</td>
<td>.68</td>
</tr>
<tr>
<td>Inspirational Motivation</td>
<td>2.77</td>
<td>.57</td>
</tr>
<tr>
<td>Intellectual Stimulation</td>
<td>2.74</td>
<td>.69</td>
</tr>
<tr>
<td>Ind. Consideration</td>
<td>3.12</td>
<td>.56</td>
</tr>
<tr>
<td>Contingent Reward</td>
<td>2.66</td>
<td>.70</td>
</tr>
<tr>
<td>Mgmt-by-Exception (A)</td>
<td>1.55</td>
<td>.90</td>
</tr>
<tr>
<td>Mgmt-by-Exception (P)</td>
<td>1.05</td>
<td>.72</td>
</tr>
<tr>
<td>Laissez-faire</td>
<td>.93</td>
<td>.77</td>
</tr>
<tr>
<td>Followership Scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ind. Thinking</td>
<td>40.60</td>
<td>8.03</td>
</tr>
<tr>
<td>Active Engagement</td>
<td>44.62</td>
<td>6.06</td>
</tr>
</tbody>
</table>

Consideration. In general, the highest scores were found in the Transformational subscales with the lower ranked scores in the Transactional ones. Table 7 shows the mean scores by leadership subscales for both the Hospital and Home Care Groups.

These scores were compared to the available literature. Bass and Avolio (1995) provide scores on nine different samples in the Technical Manual for the MLQ. Of these nine, two of the samples would appear to be more closely related to this sample since one used nurse educators, who would have the profession in common, although they are hierarchically higher than the staff nurses; the second sample used students from an evening undergraduate program, who, while not...
nurses, are less likely to be in higher management positions. A comparison of the highest mean scores on the different TF and TA factors in this sample to these two other groups show some interesting comparisons. In the Nurse Educator Group, the scores of the TF factors were higher than this sample, while in the Student Group, the scores were lower. The sample scores for this study were higher on the TA factors than the Nurse Educator Group but lower than those found overall in the student group.

This finding in this study is also consistent with McDaniel and Wolf's (1992) study that found a cascading effect of scores based on hierarchical level with nurse executive scores higher than nurse administrator scores. It is difficult to compare these scores directly with this study due to the difference in MLQ Forms. However, on those factors that were not altered between forms, one self-rated TF score was higher (Intellectual Stimulation) and one was lower (Individual Consideration) in McDaniel and Wolf's Nurse Executive and Nurse Administrators Groups than the scores for the staff nurses in this study. Of the TA factors, only Contingent Reward was comparable due to the forms, and for that factor, the McDaniel and Wolf Groups were lower.

Total Transformational and Transactional scores for this study can also be compared to McDaniel and Stumpf's (1993) study with MLQ scores for staff nurses and first line supervisors. According to these authors, “preferred norms” for the composite scores are above 3.0 on the scales and in their sample, the TF scores were “moderate” with a group means of 2.5 and $SD$ of .79. The comparative values in this study were 2.9 and .40, respectively. Transactional composites in the McDaniel and Stumpf study had an average mean score of 2.1 ($SD = .51$); the staff nurses’ scores, mean of 2.0, were slightly lower than the nurses in management, where the mean was
2.2. Similarities between the McDaniel and Wolff findings and the findings of this study support the use of Transformational leadership at all levels of nursing although a hierarchical effect is evident. It would appear that the use of leadership behaviors in nursing is similar to the use of such behaviors in other professions studied using the MLQ.

**Description of Followership Behaviors Used**

The Followership questionnaire included 20 items with two subscales, Independent Thinking and Active Engagement. As noted above, no difference was found between the Hospital and Home Care Groups for either subscale. The data were also organized so that the distinct followership styles used by the staff nurse groups could be identified. In general, this study had a larger number of Exemplary Followers, less Pragmatists and fewer Conformists and Alienated members than predicted by Kelley (1992). No staff nurses used the Passive style. Table 9 shows the specific followership styles used by respondents.

The number of Exemplary Followers reported in this study should be looked at in light of the low response rate and a nonresponse bias. The return rate of 57% may well explain why the proportions of followership styles reported were not consistent with those identified by Kelley (1992). If other sample members had responded, the proportions of people in the various followership categories might have been quite different. The absence of individuals in the Alienated and the Passive styles is intuitively consistent with a nonresponding group.
Table 9
Followership Styles by Setting

<table>
<thead>
<tr>
<th>Followership Style</th>
<th>Hospital Nurses(^a)</th>
<th>Home Nurses(^b)</th>
<th>Kelley's Estimates(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>%</td>
<td>(n)</td>
</tr>
<tr>
<td>Alienated</td>
<td>0</td>
<td>—</td>
<td>0</td>
</tr>
<tr>
<td>Exemplary</td>
<td>43</td>
<td>73</td>
<td>47</td>
</tr>
<tr>
<td>Passive</td>
<td>0</td>
<td>—</td>
<td>0</td>
</tr>
<tr>
<td>Conformist</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Pragmatist</td>
<td>13</td>
<td>22</td>
<td>13</td>
</tr>
</tbody>
</table>

\(^a\) \(n = 59\).
\(^b\) \(n = 61\).
\(^c\) From *The Power of Followership* by Robert Kelley (1992), Doubleday Currency.

Exploring Relationships Between Key Characteristics and Leadership/Followership

After exploring the potential differences based on type of agency, differences between demographic variables and leadership/followership scores were considered. One way analysis of variance (ANOVA) tests were run to look at differences in mean scores for the MLQ and Followership subscales using Basic Education and Highest Education as categorizing variables. \(t\) tests for independent means were run to look at the differences in mean scores for the subscales between those with a speciality certification and those without. No difference was found on any variable.

Finally, data analysis techniques were applied to the number of years worked as an RN, the number of years worked at the agency, and the age of the nurse. Pearson product moment correlations were calculated for these variables and scores on the MLQ and Followership subscales. There was no evidence that these
correlations are different from 0 beyond what would be expected by chance as a result of sampling error.
CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

As noted in Chapter II, prior literature has supported a belief that home care settings require different competencies than hospital settings, although little research has been done to confirm this experiential finding. The purpose of this study was to test the hypothesis that staff nurses in hospital and home care settings used different leadership and followership behaviors and to explore those behaviors as affected by key characteristics. While the findings did not support the hypothesis, the data do provide support for other conclusions. This chapter will discuss these conclusions. Limitations of the study will be noted within the context of the conclusions. Finally, recommendations will be made based on this discussion.

Conclusions

Future Study

Early on in this paper it was noted that the lack of research literature on staff nurses was of interest in a profession where the direct care nurse is the idealized practitioner. This study reinforces this interest and the first conclusion is that continued research is necessary to further define and explain staff nurse leadership. Instrumentation also poses a problem for further study. While staff nurses were able to identify leadership behaviors using the Multifactor Leadership Questionnaire, missing data and low reliability coefficients for the subscales are a concern. Since
prior use has been with nurses in hierarchical positions, comparisons were limited. The Followership Questionnaire, however, demonstrated adequate reliability in this sample. It is also limited by a lack of prior evidence which could be used for comparison.

The Effect of Setting

In keeping with the primary purpose of the study, the major conclusion derived from these data is that the hypothesis, hospital nurses will use different leadership and followership behaviors than nurses in home care, was not supported in this sample. While such a possibility still exists, the lack of a difference in this study raises other possible questions. Practitioners believe that competencies in the two settings are different and nurses have difficulty in the transition from hospital to home care staff nurse (Kraus, 1994; O’Neill & Pennington, 1996). Clinical and nonclinical skills are both potential factors and both may relate to setting. In this study, leadership and followership were hypothesized to be different in the two settings. Given the lack of support for this, reported differences in settings may well be related to some other nonclinical skill or characteristic. Additionally, this study shows that a large group of nurses do function in both settings. Assuming they are functioning adequately, intrapersonal characteristics, such as the desire to work autonomously, the need for control over one’s environment or locus of control, come to mind as possible sources of differences between hospital and home care settings. Such characteristics are supported by the differences noted in the home care setting, for example, providing care in the patient’s home and separation from peers and direct agency support.
It is also possible that leadership and followership do differ between settings, but that this difference was not identified in this study. This could well be due to unknown aspects of leadership and followership, limitations of the sample, or measurement limitations. With the size of the sample being quite small, it is possible that any differences present were not identifiable. This is especially true for those tests where only a portion of the sample was used. In the testing of the "pure" group, that is, those nurses who worked only one setting, group size decreased to 45 for the Hospital Group and 30 for the Home Care Group from the already modest total number of 69 and 67, respectively. Considering the return rate of 57%, the refined smaller sample for the Hospital Group then consisted of less than 40% of the anticipated random sample of hospital staff nurses. The gap in research on staff nurse leadership behaviors leaves many details unknown. Perhaps the reported behavioral differences occur only during times of transitions, such as when the staff nurse leaves one setting for another. Perhaps there is no difference among the nurses who responded, but there would be a difference if data were available from a representative sample of staff nurses in the two settings. Additionally, respondents were restricted to agencies that were under one corporate umbrella in a specific geographic region. A national sample might support or refute the conceptual literature. Even within this corporate group, consideration should be given to how representative this sample is to the total group, given the limited number of agencies used (three hospital settings and three home care settings) and the low response rate.

Another possibility is that the instruments used, specifically the MLQ, did not measure leadership behaviors in a manner that is relevant to the staff nurse role. The definition of leadership used for this study and inherent in the MLQ scales may not reflect leadership behavior as it is understood or carried out by staff nurses. The
amount of data missing in this study may be an indication of this type of problem. Behaviors in the MLQ are briefly stated in a general manner; terms such as group or others are used, presumably to allow readers to apply the statement to their own particular setting. However, this stretch in application may be too great for staff nurses who may fail to see the relevance in their work directly with clients.

Leadership/Followership Explored

Several conclusions develop out of the data to meet the secondary purpose of the study, that is, exploring the features of leadership and followership in staff nurses. Fundamentally, it is apparent that staff nurses do indeed use leadership and followership behaviors in their work, although transformational leadership scores were lower than those found in other groups of leaders. Transformational behaviors were used more frequently in both groups than transactional behaviors; and, the staff nurses also use the Exemplary followership style, with strong critical thinking and active, independent behaviors that add to the defined leadership behaviors. The presence of these behaviors indicate a strong resource for the profession.

The presence of this resource is in contrast to the fact that staff nurses often are not seen as leaders by themselves or some others (Bara, 1987; Patton, 1981; Roe, 1989; Stevens, 1981). This was indicated directly by one of the respondents who wrote a note on the questionnaire saying: "I do not understand why this was sent to me. I am not in a leadership position. I am a staff nurse . . ." Unable to view leadership in a clinical practice situation, or afraid of the responsibility and accountability that accompanies the role (Rimar, 1991), staff nurses may not be able to ascribe such behaviors to themselves. Such perceptions may well have altered responses to questions that discuss using leadership methods or being capable of
affecting others. Leadership scores might have been higher except for perceptions of the staff nurses themselves. Results from this study should provide some assurance that staff nurses are behaving as leaders and as independent, critical thinking followers.

Nurses are also responding to the major changes occurring in the work setting in a variety of ways (Burtt, 1997). The lower scores on the Contingent Reward scale may reflect their inability to see how they can reward others in a situation where they feel powerless and overwhelmed by change the changes described previously in the literature review. Delegating to others is also a relatively new role for the hospital RN and many nurses are dissatisfied with the process (Barter, McLaughlin, & Thomas, 1997). Such issues may therefore affect these respondents as they reacted to a survey that is patently nonclinical.

Certain key characteristics were expected to have an effect on leadership and followership behaviors. However, this study did not provide evidence supporting expectations. Formal education, either initial or the highest level attained, failed to have a relationship with leadership or followership scores. While this study adds only a very small piece of evidence in this continuing debate on the effects of education, it does provide additional information. The review of the literature done for this study identified studies providing evidence both supporting and failing to support educational differences. It is interesting to note, however, that at least one of the works noting differences was based on graduate work in nursing (Loyer & O’Reilly, 1985), and that other professions, such as Public Health, also have this issue (Erickson, 1993). Perhaps education makes a difference at the graduate level but not at the baccalaureate level, where, Manfredi and Valiga (1990) suggest, curriculum focuses on management rather than leadership.
Interpretation of the findings regarding educational differences should take into consideration the limitations of the sample regarding differences found in educational background of this sample. In general, this sample had higher numbers of Associate Degree nurses and Baccalaureate nurses in both initial and the highest education categories than those found at national levels. This may well be due to geographic location; all of the agencies were within 50 miles or less of at least one Baccalaureate program and had adequate access to educational programs. Another possibility is that nurses with more education may have been more apt to return the survey.

Relationships between demographic characteristics, (age, years as a RN, years at the agency, and certification status) and leadership or followership behaviors were not supported in this study, thus little can be said about them.

Recommendations

With the acknowledgment of these conclusions, certain recommendations can be made. First, additional study looking at leadership and followership as well as differences in hospital and home care settings should be undertaken. Most basic would be studies that look at leadership and followership from the staff nurse perspective. Focused interviews or a phenomenological approach might be considered.

It would also be worthwhile to carry out another study looking at the effect of setting on leadership/followership as this one attempted to do after redesigning key aspects. Use of a larger sample would be most helpful as would increasing the diversity of the population. A national sample of staff nurses in a variety of work settings would also allow for generalization to the larger population of staff nurses.
Methodology should take into consideration other ways to increase response rate so that the representation of the sample is increased. To avoid missing data, care should be taken that the staff nurses have a clear understanding of the researcher’s perspective of what constitutes leadership and followership behavior. Providing behavioral examples and clear definitions of each type of behavior are possible ways of ensuring such understanding.

Instrumentation aspects must also be carefully considered. The followership instrument is relatively new and has little reported evidence of reliability and validity. Thus, the tool itself may be responsible for the lack of differences found. A review of the longer version of the instrument shows refinements that may reduce social desirability response. Consequently, use of this newer instrument may well be valuable in further exploration; however, it too lacks psychometric study.

Measurement of leadership is of greater concern and poses a dilemma. Should the MLQ continue to be used, should another instrument be considered, or a new instrument developed? Each possibility has its own strengths and limitations, and researchers will need to make that decision based on their particular study.

Both the leadership and followership tools used in this study were developed for the business world. While a number of studies with nurses have been done with the MLQ, these have been limited to nurses in mid and upper managerial positions. No reported studies have been done in nursing with the followership questionnaire developed by Kelley. While nurses have felt the increasing pressure to “act like a business,” it is not difficult to suggest a difference between the typical business environment that the instruments were developed for and the environment where professional nursing is carried out. This seems especially true when considering the world of the staff nurse.
Secondly, nursing should look at what appears to be an important discrepancy between the conceptual leadership expectation for the staff nurse, what the staff nurse perceives, and what is empirically demonstrated. To do otherwise will encourage the status quo where educators will continue to teach “leadership,” employers will expect it, and staff nurses will continue to see it as something done by others, different from themselves. Attention should be given by nurses at all levels—researchers, administrators, educators, clinical practitioners, and especially staff nurses themselves.

Along with others, this author recommends development of a model of clinical leadership that provides clearer definitions of such behavior and how it is manifested in the clinical setting. Literature beyond this study also supports that such a model contain the idea of followership in some way and most importantly in a manner which focuses on the empowering aspects of the role. Since there is little work in both these areas, a qualitative methodology would provide greater understanding from the staff nurse perspective, which is unavailable in any of the current literature. This type of study could also begin to identify the discrepancies, noted above, that separate the conceptual and the practice perspective of the staff nurse as leader.

Several authors have beginning frameworks that might provide a perspective for empirical testing. Kelley and Caplan (1993) present just such a model for professional engineers that could serve as a starting point for the nursing profession. One advantage is that it incorporates the concept of Followership as it was defined for this study. A second model (Megerian & Sosik, 1996) provides theoretical links between transformational leadership and emotional intelligence (Goleman, 1995).
This model is attractive in that it provides opportunities to explore other variables that may have an effect on the use of various leadership behaviors.

In the past, leadership and management have often been used interchangeably. While no one has recommended that this be continued, it may not be helpful to split off the two concepts totally (Kurz & Haddock, 1989). Such a splitting in the nursing arena may increase the current problem of staff nurses not seeing themselves as leaders. According to Rimar (1991), it is most important that bedside nurses know that they use a style of leadership, that they are effective or noneffective as leaders, and that their choices in leadership (and followership) behaviors can have major consequences for all involved. Making decisions in these crucial areas, staff nurses do affect their clients, themselves, and others they work with, as well as their organization, their profession, and the larger community. Such decisions should not be seen as mere matters of preference.

Summary

Using a survey methodology, this study has looked at the effect of setting on the leadership and followership behaviors of hospital and home care staff nurses. Secondarily, it has explored the dimensions of such behaviors in relation to key respondent characteristics and instrument measurement. Leadership behaviors were measured using the Multifactor Leadership Questionnaire 5x-Short (Bass, 1995) and Followership was measured using Kelley’s Followership Style Questionnaire (1992). Three affiliated hospital and home care agencies belonging to a private nonprofit corporation in the Midwest agreed to participate and 238 surveys were sent to staff nurses, 50% of whom were employed in hospitals and 50% in home care agencies. One hundred and thirty-six surveys were returned for a 57% return rate. Sample
respondents were similar to nurses at the national level in age but not in education, with the sample having fewer diploma nurses and more ADN- and BSN-prepared individuals. Within the sample, the hospital and home care groups were not different in age or certification; however, home care nurses had been at their agency fewer years and spent more time than hospital nurses in direct care activities. Hospital nurses were more apt to take charge than home care nurses.

Differences between the leadership and followership behaviors of hospital and home care staff nurses were not found. The lack of support for the hypothesis suggests that other nonclinical factors may be more important to success in different work settings. These findings may be reflective of self-perception, difficulty in applying clinical behaviors to the MLQ, unknown aspects of leadership and followership, or measurement limitations. However, the findings do provide support for the premise that staff nurses use a variety of transformational and transactional leadership behaviors, although at levels below those demonstrated in prior literature for managerial nurses. Unlike prior studies, leadership and followership behavior were not explainable by education, either initial or highest educational level, or by certification.

As for Followership, among the staff nurses, 75% had exemplary Followership style, 22% had a Pragmatist style, and 3% had a Conformist style. Nurses in this sample did not have Alienated or Passive followership style. Followership behaviors may be different from the literature due to nonresponse bias.

Further study is recommended to continue to explore differences in setting and for leadership and followership in staff nurses. Methodological changes, including increasing and broadening the sample, qualitative study, and various measurement methods, should be considered. Variables affecting leadership and
followership behaviors should be explored within such studies. Further development of new or available models of clinical leadership is also recommended with delineation of how leadership and followership behaviors are demonstrated by staff nurses.

The overview on leadership and followership by Heller and Van Til (1982), although developed in the early 1980s, remains relevant today, both in American society and in the nursing profession. They note that there is a vision of leadership and followership being developed that contains a maturity unknown in prior thought, one in which followers are not child-like and passive or docile. Leaders are not omnipotent, paternal/maternal, or tyrannical. Rather, the vision has the leader and the follower interacting at an adult level, responsibly—a level that can allow an organization to meet the challenges of today and tomorrow. Staff nurses, regardless of their work setting, are the largest group of nurses in this country. Their potential influence is a resource too important to be wasted, especially as the health care system responds to the challenges of the new century.
Appendix A

Sample Job Description for Staff Nurse
Position Description

Job Title Registered Nurse II

Effective Date April 1, 1995

Patient Services Division

I. Job Summary
Accepts responsibility and accountability for the delivery of care through the use of the nursing process. Directs and guides patient and family education. Directs ancillary personnel. Cares for all types of patients on assigned patient care unit, while maintaining professional nursing standards. Practices nursing within the North Iowa Mercy Health Center professional nursing practice plan.

II. Organizational Summary
A. Reports to: clinical nurse manager
B. Supervises: none
C. Key Work Relationships: unit staff, other department staff, physicians
D. Primary Customer Group: patients and families, physicians, other department staff, and public

III. Primary Responsibilities
A. Assess patients and identifies common physical and psychosocial needs. Develops ability to identify unusual, complex physical and psychosocial needs.
B. Develops a written plan of care within 24 hours of admission. Reviews and updates the plan daily and based on changes in the patient’s condition. Provides assistance to Clinical Level I nurse in developing care plans for their patients.
C. Implements the plan of care based on standards of practice, health center policies and procedures, and patient/family needs.
D. Evaluates patient/family response to nursing interventions.
E. Provides or facilitates learning opportunities to meet the educational needs of the patient and family by assessing the learning needs and formulating and initiating a teaching plan to meet those needs.
F. Begins the patient/family discharge plan on admission.
G. Participates in activities which promote better patient care, nursing development, and professional growth.
H. Demonstrate principles of therapeutic communication skills and promotes positive relationships within the department, with other departments, and with hospital guests and clients.
I. Collaborates with members of the inter-disciplinary health care team to achieve desired patient care outcomes.
Position Description
Registered Nurse II
Page 2

J. Participates in quality improvement activities to enhance nursing practice.
K. Maintains accountability for nursing care by: identifying and reporting patient problems, participating in unit meetings, and attending appropriate inservices and education programs.
L. Provides competent care as outlined in the applicable performance standards to the population served, as identified in the description of services.
M. Supports and abides by all health center, departmental and safety policies and procedures.
N. Acts in a professional manner reflecting the mission, philosophy and values of North Iowa Mercy Health Center and Mercy Health Services.
O. Performs other responsibilities as requested by the Clinical Level III registered nurse, clinical leader, clinical nurse manager, and/or director.

IV. Position Qualifications
A. Education
1. Graduate of an accredited program in professional nursing.
2. Current RN licensure in the state of Iowa.
B. Experience
1. A minimum of two years experience in a health care setting required, acute care preferred.
C. Special Skills and Aptitudes
1. Effective verbal and written communication skills.
2. Demonstrate knowledge and support for the principles of customer relations in daily activities.
3. Maintains certification in CPR.

V. Primary Physical Requirements
A. Occasional (8-10% of work time) to continuous (80% work time) bending, crouching, reading, squatting, standing, stooping, and walking.
B. Able to lift and/or push and pull objects weighing up to 60 pounds frequently (21-50% of work time) to very frequently (51-80%).
C. Able to carry and/or push/pull objects weighing 20 to 60 pounds (11%-80% of work time) and objects weighing up to 20 pounds very frequently (51%-80% of work time).
D. Normal range of visual, auditory, touch, and verbal activity.
E. Required to perform detailed tasks, be subjected to interruptions and changing work priorities.
F. May be exposed to electrical shock, radiation, and infectious disease.
G. Able to distinguish temperature and surfaces. Possesses manual dexterity.
H. For all physical requirements, please refer to the
Position Description
Registered Nurse II
Page 3

Working Conditions and Physical Demands Worksheet. Copies are maintained in the Human Resources Department and in the Patient Services Administration office.
Appendix B

Approval Letter From the Human Subjects
Institutional Review Board
To: Dr. Uldis Smidchens  
Ms. Elaine S. VanDoren

From: Richard A. Wright, Chair  
Human Subjects Institutional Review Board

Subject: HSIRB Project # 96-10-24

Date: October 9, 1996

This is to inform you that your project entitled “Leadership and Followership in Staff Nurses Employed in Hospitals and Home Care Settings,” has been approved under the exempt category of research. This approval is based upon your proposal as presented to the HSIRB, and you may utilize human subjects only in accord with this approved proposal.

Your project is approved for a period of one year from the above date. If you should revise any procedures relative to human subjects or materials, you must resubmit those changes for review in order to retain approval. Should any untoward incidents or unanticipated adverse reactions occur with the subjects in the process of this study, you must suspend the study and notify me immediately. The HSIRB will then determine whether or not the study may continue.

Please be reminded that all research involving human subjects must be accomplished in full accord with the policies and procedures of Western Michigan University, as well as all applicable local, state, and federal laws and regulations. Any deviation from those policies, procedures, laws or regulations may cause immediate termination of approval for this project.

Thank you for your cooperation. If you have any questions, please do not hesitate to contact me.

Project Expiration Date: October 9, 1997
Appendix C
Instrumentation
Dear Nurse,

I am asking you to participate in a research study by completing the enclosed questionnaire. I know as a nurse myself, just how few moments are available for this kind of task, so, I have enclosed a bag of cocoa to encourage you and to help make it a more pleasurable activity. So, why not sit down now, relax and have a cup of cocoa on me!

Before you look at the questionnaire, I would like to give you some background for this study. As a nurse educator, I have been interested in finding out more about staff nurses and their role in hospitals or home care agencies. Your organization was of interest to me because of its size and it's willingness to allow me to approach you. I am working on my doctoral dissertation that will be looking at staff nurses as leaders and followers. I hope in addition to stimulating my thoughts, the results of this study might be used to assess the educational needs of nurses like yourself both in schools of nursing and in employing agencies. In addition, it may encourage nurse researchers to look at how well questionnaires can be used with nurses to make this educational assessment.

In this study, I am asking each nurse I contact to complete the attached questionnaire. Then I will be looking at the information given in relation to the type of employing agency - whether hospital or home care and other factors such as educational background, age, organizational indicators, and current responsibilities. Individuals participating in this study can expect to spend around 20 minutes completing the questionnaires; questions require only circling the appropriate response or providing numbers. Please respond as soon as possible within the next week.

In general there is little foreseeable risk in this material. However, consideration of your need for confidentiality has been addressed in the following ways. First, your identity and personal information will be kept confidential; only I will have access to this information. Second, while I have not coded the questionnaires I have provided a coded post card for you to return at the same time you return the questionnaire for follow-up purposes. Only I know the listing of codes and names and the list will not be taken to any agency. Lastly, the only information going back to your agency will be a summary of the total study.

Your participation in this study is strictly voluntary. Completion of the questionnaire indicates your willingness to participate. Your decision as to whether you participate will be known only to me unless you choose to provide that information to others and you may withdraw your participation at any time. For answers to questions pertaining to this study or to your role, do not hesitate to call me at the number listed above. I have an answering machine and will get back to you as soon as I can. As a participant, you may also contact Western Michigan University, specifically, the Chair of the Human Subjects Institutional Review Board at (616)387-8293 or the Vice President for Research at (616) 387-8298 if any questions or problems arise during the course of this study.

So, with that in mind, I suggest you take another sip of cocoa and begin the questionnaire. There are no right or wrong answers to any of the questions, only what is true for you. And, I thank you again for taking your valuable time to provide this information.

EVD: Cvtrr1

Principle Investigator and Advisor: Uldis Smitdchens (616)387-3889
STAFF NURSE LEADERSHIP AND FOLLOWERSHIP SURVEY

PART 1: GENERAL INFORMATION
1. How many years have you been practicing as an RN? _____ years
2. How many years have you worked at this agency? _____ years
3. What is your age? _____ years
4. What is your basic RN education?
   - Diploma ______
   - Associate Degree (ADN) ______
   - Bachelor's in Nursing Degree (BSN) ______
   - Other ______________________
5. What is your highest educational degree:
   - Diploma ______
   - Associate Degree (ADN) ______
   - Bachelor's in Nursing Degree (BSN) ______
   - Bachelor's not in Nursing ______
   - Master's in Nursing (MSN or MS) ______
   - Master's not in Nursing ______
6. Are you certified in your area of expertise? Yes ____ No _____
7. Do you take charge nurse responsibility? Never _____ Less than once/week _____
   1-2 times/week _____ Less than 2 times/week _____
8. Do you delegate work to LPNs or unlicensed personnel such as nurse aides & technicians? Yes ____ No _____
9. Do you routinely work in direct care both on acute inpatient units and in home care settings? Yes ____ No _____
10. On the average, what percent of your work time is spent in direct care with clients?
    - 0-25% ______
    - 26-50% ______
    - 51-75% ______
    - 76-100% ______

PART 2: FOLLOWERSHIP SURVEY: Developed by Dr. Robert Kelley
For each statement, please use the scale below to indicate the extent to which the statement describes you. Think of a specific but typical followership situation and how you acted.

0 1 2 3 4 5 6
Rarely Occasionally Almost always

1. Does your work help you fulfill some societal goal or personal dream that is important to you? ...........................................................0 1 2 3 4 5 6
2. Are your personal work goals aligned with the organization's priority goals? ..................0 1 2 3 4 5 6
3. Are you highly committed to and energized by your work and organization, giving them your best ideas and performance? ...........................................................0 1 2 3 4 5 6
4. Does your enthusiasm also spread to and energize your coworkers? .........................0 1 2 3 4 5 6
5. Instead of waiting for or merely accepting what the leader tells you, do you personally identify which organizational activities are most critical for achieving the organization's priority goals? .................................0 1 2 3 4 5 6

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6. Do you actively develop a distinctive competence in those critical activities so that you become more valuable to the leader and the organization?  

7. When starting a new job or assignment, do you promptly build a record of successes in tasks that are important to the leader?  

8. Can the leader give you a difficult assignment without the benefit of much supervision, knowing that you will meet your deadline with highest quality work and that you will “fill in the cracks” if need be?  

9. Do you take the initiative to seek out and successfully complete assignments that go above and beyond your job?  

10. When you are not the leader of a group project, do you still contribute at a high level, often doing more than your share?  

11. Do you independently think up and champion new ideas that will contribute significantly to the leader’s or the organization’s goals?  

12. Do you try to solve the tough problems (technical or organizational), rather than look to the leader to do it for you?  

13. Do you help out other co-workers, making them look good, even when you don’t get any credit?  

14. Do you help the leader or group see both the upside potential and downside risks of ideas or plans, playing the devil’s advocate if need be?  

15. Do you understand the leader’s needs, goals, and constraints, and work hard to help meet them?  

16. Do you actively and honestly own up to your strengths and weaknesses rather than put off evaluation?  

17. Do you make a habit of internally questioning the wisdom of the leader’s decision rather than just doing what you are told?  

18. When the leader asks you to do something that runs contrary to your professional or personal preferences, do you say “no” rather than “yes”?  

19. Do you act on your own ethical standards rather than the leader’s or the group's standards?  

20. Do you assert your views on important issues, even though it might mean conflict with your group or reprisals from the leader?
The Multifactor Leadership Questionnaire Leader Form (5x-Short) is available from:

Mind Garden, Inc., P.O. Box 60669, Palo Alto, CA 94306. (415) 424–8493.
BIBLIOGRAPHY


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