



## CHAPTER 28

# Visionary leadership for a 'greying' health care system

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## FRAMEWORK

Perhaps the last chapter is the one that unites the major underlying theme of interdisciplinary teamwork and effective leadership. Leadership relates to all areas of practice and is the means to influence change. The authors discuss current and future health care systems and their impact on leadership. The lack of research into leadership in aged care organisations is a factor that influences the future direction of service delivery. Person-centered care is a concept that acute hospitals are finding difficult to implement. Aged care services, however, have been changing toward this care approach for some time. There is merit in opening dialogue between service providers to create the preventative and primary care system that is required for the future. The vignette in this chapter gives much food for thought and opens a possible vision to consider. [RN, SG]

## Introduction

Our health care system, consumers and providers, are ageing. People over the age of 65 use the most bed days, consume the most community care and represent the majority of residents in long-term care. Health professionals are increasingly over the age of 45. To ensure resources are used appropriately and consumers receive quality care requires visionary leadership. This is not a time for doom and gloom, but it is necessary that government, health professionals, industry providers, researchers and educators *do things differently*. More money for more of the same is not the answer. Too often management prevails and leadership is forgotten as individuals in leadership positions, but without leadership qualities and skills,

bounce from managing one crisis to the next. This book is about improving care for older people; for the ideas and innovations to flourish, leadership is essential. So what do we know about leadership in health care?

## What do we know about leadership in the health care context?

Despite widespread acknowledgment of the importance of effective and responsive leadership in the health care context (Daly et al 2004; Jackson 2008a; Schwartz & Tumblyn 2002), the scholarly discourses around leadership in health care are still relatively scant. Recently, Dowton (2004) considered:

articles indexed over more than 30 years in five Australian journals (The Medical Journal of Australia, Australian & New Zealand Journal of Surgery, Australian & New Zealand Journal of Psychiatry, Australian Family Physician, and the Journal of Internal Medicine and its predecessor), and could barely find 50 articles dealing with leadership ... Furthermore, very few of these 50 articles, editorials, or letters provided substantial information or commentary on the makings of leadership. One regionally relevant and accessible electronic archive of medical interest, the eMJA, does not index 'leadership', and in over 3800 entries has but three items with 'leadership', 'lead' or 'leader' in the title.

(Dowton 2004: 2)

Vance and Larson (2002) undertook a review of leadership research in health care and business for the period 1970 to 1999. From a review of 6628 articles, they concluded that to date, the literature on leadership in the discourses around health and business:

has been primarily descriptive. Although work in the social sciences indicates that leadership styles can have a major influence on performance and outcomes, minimal transfer of this work to the health system is evident. Limited research on leadership and health care outcomes exists, such as changes in patient care or improvements in organisational outputs. In this era of evidence-based practice, such research, though difficult to conduct, is urgently needed.

(Vance & Larson 2002: 165)

On the other hand, Hamlin (2002) notes that:

much research has been done over the past thirty years or so concerning the study of managerial and leadership behaviour. However, the majority of studies have almost exclusively been focused on the 'absolute' or relative 'frequency' of observed behaviours, or on the amount of time devoted to particular activities, and not on the 'quality' or 'mastery' of specific behaviours associated with either effective or ineffective management and leadership.

(Hamlin 2002: 248)

Nursing — as opposed to health care generally — has a more established literature on leadership that has likely been brought about by the pressures faced by the discipline over the past two decades. In the Australian context, these pressures have been caused (at least in part) by the transfer of education from hospitals to the education sector. This transfer resulted in a loss of a layer of senior nurse leaders from the health sector, as many educators and tutor sisters moved from health into education (Mannix et al 2006). Furthermore, the transfer

created a need to ensure that leadership models to support the entry of new graduates were in place. Internationally, nursing has been grappling with acute and chronic shortages of nurses, particularly in specialty areas. These pressures have resulted in exploration of various leadership models that might assist in retaining staff and developing a sustainable workforce (see, for example, Thyer 2003; Jackson 2008a). The nursing literature identifies various models and styles of leadership, ranging from the very bureaucratic and autocratic styles of leadership, through to the charismatic and relationship-based approaches. The latter approaches have found particularly fertile ground in nursing (Jackson 2008b) and we have seen the emergence of models that embrace concepts such as mentoring, and that focus on creating and enhancing collegial relationships and personal growth (Grossman 2007).

## How does the current and future health care context impact leadership?

Leaders in health are challenged to lead constituents within the context of an ever-changing, highly politicised and volatile environment. The health system in Australia has undergone enormous change in the last 2 decades. It is clear that this change will continue as governments strive to meet current and projected challenges, while working to create new systems of care that are cost-effective, based on evidence, and that are equitable, accessible, responsive and of good quality. Health disparities exist in Australia, and Indigenous and other marginalised people in particular have needs that must be addressed so that their health outcomes match those of the mainstream population. The needs of the population for health care are predicted to increase due to a number of factors; for example, population growth, the growing incidence and burden of chronic disease, and ageing. Growth in the prevalence of chronic disease is likely to be influenced by alcohol and drug abuse, poverty, socioeconomic disadvantage, unhealthy lifestyle and diet, and possibly climate change (Australian Government 2008).

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In 2006, people over 65 years constituted 13% of the population, and this is predicted to increase to 24% by 2036 (Australian Government 2008). The burgeoning costs of acute care and management of chronic diseases (many of which are a consequence of lifestyle) are currently under scrutiny. Without changes in health involving the community, these costs may become unaffordable. A re-conceptualisation of health and health care may see more expenditure on disease prevention and health promotion, which has been held at low levels in the past. It is clear from the recent Australia 2020 Summit that health care reform is on the agenda (Australian Government 2008).

Change in the Australian health system, in the last 2 decades, has presented significant challenges for health professional groups and required them to adapt to: new health service policy environments; professional role changes; new models of care; diminishing resources for health with concomitant increases in demand for health services; workforce supply and demand issues; the rise of consumerism; rising levels of litigation in health care; and greater levels of

uncertainty. This is a global phenomenon across developed countries. Leatt and Porter note that:

In the last decade, health care throughout the world has experienced broad strategic management strategies, such as re-structuring, regionalisation, downsizing of personnel, reduced bed capacity, and decreased funding. At the same time consumers are expecting higher-quality services, more information about treatment options, as well as more accountability for performance. At the service delivery level, health professionals are burnt out, feel undervalued and under-rewarded, have lost trust in their employers and governments, and appear dissatisfied. Health service workers appear more resistant to change and less open to creativity and to innovation.

(Leatt & Porter 2003: 22)

Conflict has also been a feature of the health care landscape in Australia in the last decade, often between senior clinician leaders in health care and health bureaucrats, because of differing perceptions regarding the most appropriate distribution of resources for health care, health service priorities and sometimes resentment at what may be seen as unnecessary interference by government in roles and accountabilities of health professionals. Philosophical incongruence (rhetoric versus reality) can also impact on harmonious development and delivery of health care. Many health care professionals are, for example, educated in a patient-centered approach, a principle embedded in the rhetoric of many health care systems, which then demand tight economic efficiency in resourcing to a level where it becomes impossible to operationalise the aspiration of 'patient-centeredness' in actual practice (Jackson & Raftos 1997; Lumby & Duffield 1994). The driver can become a systems focus on leanness and getting tasks completed quickly. The notion of multidisciplinary teams is also a part of the rhetoric, yet team dysfunction often undermines efforts to assure quality care. Indeed the notion of 'team' in health care remains contested, and not all health professionals subscribe to the notion of multidisciplinary health care as appropriate to all contexts (Saltman et al 2007). This is problematic, and adverse events in health care can be attributed to a number of factors, including poor collaboration and communication in health care teams (Manojlovich et al 2008).

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Manojlovich and colleagues observe that:

Research from other disciplines interested in finding solutions has been recently focused on two key areas: conceptualising the hospital as a high-reliability organisation and developing a safety component in the overall organisational culture. In both cases, teamwork and collaboration are stressed (Baker et al 2006, Saint et al 2005), and nursing collaboration is becoming more prevalent in safety culture studies.

(Manojlovich et al 2008: S12)

Recent expert deliberations about how the health system of the future will need to be structured foreshadow a system which is much more focused on prevention and primary care — one that is 'patient centric' rather than 'hospital and physician centric' (Talsma et al 2008: S19). In Australia, the recently established National Health and Hospitals Reform Commission will address a number of key themes in its work in efforts to reshape health care systems. It will provide advice on the

framework for the next Australian Health Care Agreements (AHCAs), including (Council of Australian Governments 2007: 5):

- robust performance benchmarks in areas such as (but not restricted to) elective surgery, aged and transition care, and quality of health care
- reducing inefficiencies generated by cost-shifting, blame-shifting and buck-passing
- better integration and coordination of care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health
- bringing a greater focus on prevention to the health system
- better integration of acute services and aged care services, and improving the transition between hospital and aged care
- improving frontline care to better promote healthy lifestyles and prevent and intervene early in chronic illness
- improving the provision of health services in rural areas
- improving Indigenous health outcomes
- and providing a well qualified and sustainable health workforce into the future.

The scale and breadth of these issues, which may be embraced in any health system reform agenda, appear daunting. Workforce in health will continue be one of the major issues into the future. This is a global challenge that will need to be met to enable adequate delivery of health care (World Health Organization [WHO] 2006). If ambitious reforms to health care and its delivery are to be realised, then role changes and the nature of health work broadly will need to be reshaped. The model for the health workforce and health professions (including how they are educated) as it currently exists is unlikely to be able to deliver what will be needed in health care in the future.

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The health environment is also challenged by chronic and acute staff shortages, and an ageing workforce (Jackson 2008c; Watson 2005). This challenges leaders to work to create optimal environments that are supportive and contribute to healthy and positive workplaces. Indeed, the need for good leadership in current health care systems has been acknowledged across a range of health professional groups (Daly et al 2004; Davidson et al 2006; Dowton 2004; Firth-Cozens & Mowbray 2001; Jackson 2008a; Leatt & Porter 2003). In addition, the dearth of leaders in clinical practice in health systems and the need for growth in leadership capacity have also been clearly articulated as fairly urgent priorities in health care.

Leadership capacity is seen as an important part of the solution to inefficient, sub-optimal management and poor co-ordination of services in health care, improved patient/client care, and the realisation of improved health outcomes (Firth-Cozens & Mowbray 2001; Wong & Cummings 2007). Some experts argue that existing governance models in health care are anachronistic and not appropriate to contemporary management challenges and needs (Schwartz & Tumblin 2002). In considering doctors as leaders, Gregory (2006) observes that medical practitioners are required to shift from traditional models of care to those that foster integrated care delivery, development of collaborative partnerships and relationships, and facilitate patient self-management. Effective leadership

is needed to smooth the progress of these cultural changes. Dowton (2004: 3) argues that:

Leadership is ultimately a social function within an organisation or group. Any consideration of leadership which begins with aphorisms about influence, control, motivation, inspiration, leading by example and so forth, avoids the need to consider the nature of organisations of the modern world. Regrettably, the role of leaders in modern professional and service organisations often continues to focus on a hierarchical view of leadership as a part of the mechanical view of organisations (i.e., thinking of an organisation as a machine in which all parts can be understood in detail). In such a view, power, control and outcomes arise through the division of labour and differentiation of functions — the command and control model. Significant parts of health care systems in Australia remain locked in this paradigm.

Health care is an extremely complex and highly political area. Effective leadership will be crucial in achieving any improvements in the health system and in health care in the future. This has implications for health professional education and the sustainability of health systems and the future of discrete health disciplines. Capacity building for leadership roles in health care needs to be firmly on the agenda. There is evidence to support the view that the current model of health system and health care can actually constrain efforts to provide effective leadership in many settings. Power, influence, control and tradition are factors in this, and achieving sustainable change at system, organisational, or unit level requires some examination of these issues.

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## Who can be a leader?

The capacity to provide effective leadership should not be seen as linked to positional power only; all members of a team can exercise timely and effective leadership (Daly et al 2004; Jackson 2008a; Kouzes & Posner 2002). Leaders without positional power exert influence through persuasive means (Jackson 2008a), and so would likely have highly developed interpersonal skills. Indeed, in understanding that leaders can emerge from any level of an organisation, there is recognition that leadership is associated more with activities, personal qualities and characteristics than position and status (Jackson 2008a).

☞ **All members of a team can exercise timely and effective leadership.**

In arguing the merits of leadership as an 'activity', Heifetz (a Psychiatrist and Leadership Academic at Harvard University) notes:

This allows for leadership from multiple positions in a social structure. A President and a clerk can both lead. It allows for use of a variety of abilities depending on the demands of the culture and the situation. Personal abilities are resources for leadership applied differently in different contexts. As we know, at times they are not applied at all. Many people never exercise leadership, even though they have the personal qualities we might commonly associate with it. By unhooking leadership from personality traits, we permit observations of the many ways in which people exercise plenty of leadership everyday without 'being leaders'.  
(Heifetz 1994: 20)

Within the complex field of health care, leadership capacity is perhaps best guided by agreed levels of legitimacy (Heifetz 1994), competency and scope of practice within clinical care teams. In recent times, frameworks that guide clinical decisions across levels of health workers in some fields could assist in this regard. Individuals need, however, to be taught to exercise good leadership. As Dowton notes, 'Clinical mastery or eminence in discipline-specific research does not necessarily translate into an ability to lead' (Dowton 2004: 2).

## Being and growing leaders

Leadership is a complex activity and an in-depth discussion of all theories of leadership is beyond the scope of this chapter. Kouzes and Posner (2002: 20) define leadership, in part, as 'an identifiable set of skills and practices that are available to all of us, not just a few charismatic men and women'. Leadership can be conceptualised in many ways; for example, as an activity (Heifetz 1994) or a relationship (Kouzes & Posner 2002).

Leaders are said to have a range of qualities that they bring to bear in leading. Leaders are said to have 'initiative, self-control, commitment, talent, honesty, credibility and courage' (Kelley 1988: 146), and emotional intelligence and vision (Jackson 2008a). They are able to demonstrate credibility (Kouzes & Posner 2002) and exercise 'power and authority and influence' (Heifetz 1994: 20). Effective leaders can facilitate the development of high performing teams, which is reflected in organisational performance, and work environments that are conducive to good performance and high levels of job satisfaction for many employees. They are able to inspire commitment to organisational goals, and motivate and enthuse staff. Good leaders are also concerned with development and maintenance of work environments that promote psychological and physical safety where staff retention is optimised. Sutton (2007) argues that civility in the workplace has a bearing on organisational performance and so there is an imperative on leaders to actively promote workplace civility and appropriately manage incivility.

Though leadership qualities held by individuals will often become apparent, even in very hierarchical and bureaucratic environments, there are certain leadership styles that will facilitate and nurture the leadership potential of constituents, while other leadership approaches can have the opposite effect (Jackson 2008a). Good leaders facilitate the development of leadership potential in others in the organisation. This can be achieved through providing opportunities to lead and in ensuring mentoring or other supportive frameworks are in place to support individuals to develop leadership skills.

### **There are certain leadership styles that will facilitate and nurture the leadership potential of constituents.**

Kelley makes the point that:

We are convinced that corporations succeed or fail, compete or crumble, on the basis of how well they are led. So we study great leaders of the past and present and spend vast quantities of time and money looking for leaders to hire and trying to cultivate leadership in the employees we already have...Leaders matter greatly. But in searching so zealously for better leaders we tend to lose sight of the people these leaders will lead. Without his armies, after all, Napoleon was just a man with grandiose ambitions. Organisations stand or fall partly on the basis of how well their followers follow.

(Kelley 1988: 142)

**He suggests that:**

... effective followers share a number of essential qualities:

- they manage themselves well
- they are committed to the organisation and to a purpose, principle, or person outside themselves
- they build their competence and focus their efforts for maximum impact
- they are courageous, honest, and credible.

(Kelley 1988: 144)

Some of the great leaders include John F Kennedy, Martin Luther King, Emily Pankhurst, Nelson Mandela and Aung San Sui Kyi. Although they fought for different things, in different ways they shared the capacity to get others to see their vision and follow their dreams. All suffered extraordinarily for their dreams. Leaders in our health care system are not asked to die or be imprisoned for their beliefs, but it does take courage to lead in any context. Ours is a society that by and large does not like change — leadership inevitably brings change. By definition leaders face resistance, hostility, criticism and constant opposition. Sharing the vision and the leadership across all levels of an organisation (from the gardener to the board chair) increases buy-in and a leader '... is best when people barely know he (sic) exists. When his work is done, they will say: "we did it ourselves"' (Lao Tzu 600BC–531BC). The following vignette demonstrates how visionary leadership in the care of older people might look.

**VIGNETTE**

Franklin Covey (2008) argues that 'great leaders see people as whole — body, heart, mind and spirit and work to unleash their full creative potential'. How apt is such a definition in a context where the aim is to provide person-centred care!

Imagine a RACF (Visa A) that has community, low and high care. The first thing you notice is that there are four very different entrances:

- 1 one has an oriental feel to it — peaceful lilies, frangipanis and orchids give an amazing aroma and welcoming ambience
- 2 one has a large veranda and hammocks hanging under gum trees
- 3 one has an emergency sign and looks more like a hospital entry
- 4 one has a 'typical' suburban entrance.

Before you even reach an entrance, residents, families and staff look up from where they are sitting or gardening to welcome you. One older man has a cat on his lap, another is feeding the parrots. Once in the front door the themes are embedded in the décor, staff clothing and food smells. There is a sense of continuity between the outside and inside environments; ample windows provide natural light and stunning views, and nowhere do you feel enclosed. Although each unit has a common theme, each room reflects the individual's life. You can learn so much about the resident just from looking around their space. There is no feeling of rush. There is lots of laughter but otherwise it is very quiet. You note some residents have earphones and are watching or listening to their chosen music/show (at their own required noise level). Also of note are the spaces set aside for staff use, and ample computers and equipment to support them to assist residents.

There is a salon offering beauty treatments, hair cuts/styling, massage, and a café service — all available to staff, family and residents as well as the public. A top class restaurant is frequented by community members; children populate many areas as they arrive and leave the kindergarten; local council have their council meeting room adjacent to the restaurant; a number of gift shops surround the café area just like they do 'down town'. A deal has been done to establish a small cinema featuring classics and movies being studied by the local high school. Banjo and accordion seem to be the preferred choices of the buskers! The children clap and request old favourites. An outside area has been leased to a nursery on the understanding that the residents can assist with gardening and a dementia sensory garden be maintained within the home. A small bowling green provides for male and female socialising while the men's shed is strictly secret men's business. A chapel offers solace but also joy as the local choir practises there weekly.

The staff all have their own portfolios for which they are responsible — this includes keeping up to date with research and running workshops for the home. The one running today is the gardener teaching what he has learned about the role of gardens in palliative care. Tomorrow the handyman and the Board Chair plan to discuss the impact colour can have on mood. One of the GPs along with a nurse and clinical psychologist recently presented on depression assessment and intervention. Alzheimer's Australia runs a support session each week for carers, both paid and unpaid.

The DON has an adjunct appointment with the local university and has recently completed a professional doctorate in leadership — he insists that all staff develop in new areas and supports them to do so. In addition, he knows that teaching is the best form of learning, so Visa A offers short courses for their own staff, and also for community members. All staff are expected to offer some form of community service and preceptorship for students.

The emergency unit receives people over the age of 75 and has a triage team of aged care experts. Older people are usually treated at Visa A and sent home with services; occasionally they are admitted to an acute hospital for surgery or expensive tests. Visa A offers triage, short stay, day surgery, rehab, palliative care and community services. It also offers a tele-health service to a large rural health provider. The diversification of services has proven to be economically profitable, has assisted in recruiting staff, and importantly provides a better service to older people. The involvement of the community raises revenue but also gives a sense of ownership and understanding of care needs and services. Some of the older people are involved with a community-run soup kitchen — they love it!

Staff really want to work here because it is interesting. They are able to make decisions and be accountable in their portfolio; it is worth learning because you can actually put into practice what you have learnt. When frustration and exhaustion creep in — and they do — the chapel, café, beauticians and shops remind staff their efforts are worthwhile and valued.

The time that used to be wasted in paper documentation is now used to really assess and evaluate care. Staff have designated a couple of computer experts to check regularly online for new guidelines and valid tools. The documentation no longer reflects 'nursing goals' or 'medical orders' — all documents now use terms such as 'resident's goals' and 'resident's strengths'.

'Handover' has become HOUSE: handover using scrutiny and evidence (see Ch 26). This time is where the staff use their CSI skills (see Ch 26) and evidence and brainstorm to put all the pieces together and resolve complex care issues. The resident's needs take



precedence over the tasks to be done. Occasionally a new staff member (or dinosaur) uses language like 'the demented' and immediately the team leader stops and staff discuss the conflict between labelling and person-centred care.

One of the offshoots of the computer age is that Visa A has developed a collaboration with a facility in Sweden that enables sharing of new ideas, benchmarking and staff exchanges. Another is the extent to which assistive technology has allowed many clients to be more independent. The facility is not called 'residential' — people do not come there to 'reside'. They come for specialist care. So more fitting is: Specialist Assessment Facility, Emergency and Transdisciplinary support for older people: colloquially known as SAFE-T! This multipurpose centre has saved older people from days on trolleys at the other hospital and all staff focus on holistic care, advanced care planning, prevention of functional decline and, where appropriate, palliation.

How is this possible?

- At the board level: be in touch with futuristic thinking; ensure the philosophy and planning are embedded; build collaborative community partnerships; and invest in changing the culture — 3 days of Franklin Covey (2008) may save/make you millions! Dare to diversify.
- At the management level: inspire an ideas culture; be flexible; laugh a lot; try new things; tell all stakeholders they are valued as people; be engaged in education and research; role model person-centred evidence-based care; constantly remind all staff of the vision; question staff as to why they do what they do when they do it (excite them about quality *not* just compliance!); feed to the board data on which to base decisions; create exciting career pathways.
- At the bedside and in the garden: constantly question if there may be a better way; be person-centred; be flexible; be a detective — find and use all of the evidence. This data is vital to resident outcomes *and* organisational decision making.

Have a shared philosophy and vision *but* within that be creative, keep learning and thinking and enjoying making a difference.

## Conclusion

Though it is seldom easy, leadership can be challenging and rewarding. Effective leadership in today's volatile health context requires courage, vision and the ability to create care environments in which organisational objectives can be achieved, while simultaneously ensuring positive and supportive working settings for staff. In aged care, there is real scope for leaders to make a difference and contribute to creating high quality, flexible and responsive living and care settings, and stimulating, rewarding and exciting working environments. Through exercising skilled and courageous leadership 'Visa A' could become an attainable vision for the future.

## Reflective questions

- 1 Change of direction in any system of care delivery takes courage and commitment. How can Boards and CEOs influence a visionary approach to person centric care delivery?
- 2 A complex system not only has to provide care for clients but also has to value its staff. How can an organisation become person-centric for all concerned in the system?

- 3 Daring to be different is often tried but not sustained. Consider the factors that can impede a new vision from being followed.
- 4 New ways of doing work are needed in aged care services. The workforce is ageing itself and younger workers are not being attracted to the field. Various incentives are currently being offered to attract health care professionals to work in aged care. Consider the advantages as well as the disadvantages of aged care work. Sell your job to a new prospective employee.

## References

- Australian Government 2008 Australia 2020 Summit Long-term Health Strategy. Unpublished, Canberra
- Council of Australian Governments 2007 National Health and Hospitals Reform Commission Terms of Reference. Communique, 20 December 2007. Online. Available: [www.coag.gov.au/coag\\_meeting\\_outcomes/2007-12-20/cooag20071220.pdf](http://www.coag.gov.au/coag_meeting_outcomes/2007-12-20/cooag20071220.pdf) [accessed 18 Aug 2008]
- Daly J, Speedy S, Jackson D (eds) 2004 *Nursing Leadership*, Churchill Livingstone, Sydney
- Davidson P M, Elliott D, Daly J 2006 Clinical leadership in contemporary clinical practice: Implications for nursing in Australia. *Journal of Nursing Management* 14:180–7
- Downton S B 2004 Leadership in medicine: where are the leaders? *The Medical Journal of Australia* 181:652–4 (eMJA)
- Firth-Cozens J, Mowbray D 2001 Leadership and quality of care. *Quality in Healthcare* 10:ii3–ii7
- FranklinCovey 2008 Effectiveness to Greatness. Online. Available: [www.franklincoveysouthasia.com/pdf/From\\_Effectiveness\\_to\\_Greatness.pdf](http://www.franklincoveysouthasia.com/pdf/From_Effectiveness_to_Greatness.pdf) [accessed 7 Jan 2009]
- Gregor A 2006 Doctors as leaders in the NHS. *Clinician in Management* 14:163–6
- Grossman S 2007 *Mentoring in Nursing: A Dynamic and Collaborative Process*. Springer Publishing Company, New York
- Hamlin R G 2002 A study and comparative analysis of managerial and leadership effectiveness in the National Health Service: an empirical factor analytic study within an NHS Trust hospital. *Health Services Management* 15(4):245–63
- Heifetz R A 1994 *Leadership Without Easy Answers*. Belknap Press, Cambridge
- Kelley R E 1988 In praise of followers. *Harvard Business Review*, November–December, 142–8
- Jackson D 2008a Servant leadership: A framework for developing sustainable research capacity in nursing, *Collegian* 15(1):27–33
- 2008b Random acts of guidance: personal reflections on professional generosity. *Journal of Clinical Nursing* (in press)
- 2008c Retiring from nursing: Can we avoid the retirement brain drain? *Journal of Clinical Nursing* (in press)
- Jackson D, Raftos M 1997 In uncharted waters: confronting the culture of silence in a residential care institution. *International Journal of Nursing Practice* 3(1):34–9
- Kouzes J M, Posner B Z 2002 *The Leadership Challenge*, 3rd edn. Jossey Bass, San Francisco
- Lao Tzu 600BC–531BC Online. Available: [http://thinkexist.com/quotation/a\\_leader\\_is\\_best\\_when\\_people\\_barely\\_know\\_he/214091.html](http://thinkexist.com/quotation/a_leader_is_best_when_people_barely_know_he/214091.html) [accessed 7 Jan 2009].
- Leatt P, Porter J 2003 Where are the healthcare leaders? The need for investment in leadership development. *Health Care Papers* 4(1):14–31

- Lumby J, Duffield C 1994 Caring nurses: the dilemmas of balancing costs and quality. *Australian Health Review* 17(2):72–83
- Mannix J, Faga P, Beale B et al 2006 Towards sustainable models for clinical education in nursing: an on-going conversation. *Nurse Education in Practice* 6(1):3–11
- Manojlovich M, Barnsteiner J, Burns Bolton L et al 2008 Nursing practice and work environment issues in the 21st Century: a leadership challenge. *Nursing Research* 57(1S):S11–S4
- Saltman D C, O'Dea N A, Farmer J et al 2007 Groups or teams in health care: finding the best fit. *Journal of Evaluation in Clinical Practice* 13(1):55–60
- Schwartz R, Tumblyn T 2002 The power of servant leadership to transform health care organisations for the 21st century. *Archives of Surgery* 137:1419–27
- Sutton R 2007 *The No Asshole rule: building a civilised workplace and surviving one that isn't*. Sphere, London
- Talsma A, Grady P, Feetham S et al 2008 The perfect storm: patient safety and nursing shortages within the context of health policy and evidence-based practice. *Nursing Research* 57(1S):S15–S21
- Thyer G 2003 Dare to be different: transformational leadership may hold the key to reducing the nursing shortage. *Journal of Nursing Management* 11(2):73–9
- Vance C, Larson E 2002 Leadership in business and health care. *Journal of Nursing Scholarship* 34(2):165–71
- Watson R 2005 The global shortage of registered nurses. *Journal of Clinical Nursing* 14(4):409
- Wong C A, Cummings G G 2007 The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management* 15:508–21
- World Health Organization 2006 *The world health report 2006: working together for health*. Online. Available: [www.who.int/hrh/whr06/en/index.html](http://www.who.int/hrh/whr06/en/index.html) [accessed 18 Aug 2008]



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