How does a clinical governance framework contribute to the changing role of nurse leaders in Fiji?

Thesis submitted by

Lee Stewart

RN, RM

Diploma in Teaching (Nursing) (CAE, Armidale)

Bachelor of Health Science (Nursing) (CQU, Rockhampton)

Postgraduate Certificate of Education (JCU, Townsville)

Master of Dispute Resolution (UTS, Sydney)

In August 2007

for the degree of Doctor of Philosophy

In the School of Nursing, Midwifery and Nutrition

James Cook University

STATEMENT OF ACCESS

I, the undersigned, author of this work, understand that James Cook University will make this thesis available for use within the University Library and, via the Australian Digital Theses Network, for use elsewhere.

I understand that, as an unpublished work, a thesis has significant protection under the Copyright Act and, I wish this work to be embargoed until: June 2008.

_____ _____

Signature **Date**

ELECTRONIC COPY

I, the undersigned, the author of this work, declare that the electronic copy of this thesis provided to the James Cook University Library is an accurate copy of the print thesis submitted, within the limits of technology available.

_____ _____

Signature **Date**

STATEMENT OF SOURCES

DECLARATION

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from the published or unpublished work of others has been acknowledged in the text and a list of references is given.

_____ _____

Signature **Date**

STATEMENT ON THE CONTRIBUTION OF OTHERS

This thesis has been made possible through the support of my supervisors as follows:

Supervisors:

Primary Supervisor: Professor Kim Usher
School of Nursing, Midwifery and Nutrition, James Cook University

Secondary Supervisor: Professor Colin Holmes
School of Nursing, Midwifery and Nutrition, James Cook University

ACKNOWLEDGEMENTS

There are a number of people – colleagues and friends – who have contributed in some way to the development and completion of this thesis through their gift of time, advice, encouragement and support.

I am indebted to Professor Kim Usher for her continuing patience, careful supervision and incredible encouragement throughout the years of my candidature. My appreciation is also extended to Professor Colin Holmes for his valuable contribution to the completion of this thesis. Thanks also to Dr. Kim Foster and Professor Debra Jackson for their generous feedback regarding the thesis.

I would like to express my deep and sincere appreciation to the nurse leaders of Fiji, especially the key participants who assisted with this study, unselfishly sharing their time, thoughts and ideas about their experience of being nurse leaders in Fiji. In addition, my gratitude is extended to all personnel in the Fiji Ministry of Health, who unfailingly supported me during my time in Fiji. This thesis is the story of Fiji from a health care perspective, and the key participants' experiences during the time of the study make up much of this thesis.

I would also like to thank my family, friends and work colleagues for their continued encouragement, support and tolerance during the years of my candidature. My particular thanks to Margaret Heslop for her unfailing support and belief in me and to my mother, Betty Stewart, for her patience with my long absences from much of family life. My gratitude also to my colleagues in the School of Nursing, Midwifery and Nutrition who tolerated the 'highs' and 'lows' involved in completing this study and offered their unfailing support. Particular thanks to my colleagues Kim Foster, Pauline Taylor, Tanya Park and Nichole Harvey for listening during the hard times. Thanks also to my colleagues and fellow students David Lindsay and Joanne Tollefson for our efforts to 'keep each other on track'.

Finally, I dedicate this thesis to my late father, Allan George Stewart, who taught me to appreciate the joys of reading and writing; and to my late grandmother, Ruby Carlyle Egan Stewart, who kept giving me 'Cherry Ames' books as Christmas presents when I was a child in the hope that I would become a nurse. Dad and Nana, this thesis is for you.

KEY TO TRANSCRIPTS

In the presentation of the research findings (Chapters 4, 5 and 6) and elsewhere where excerpts from the participants are included, the following abbreviations and font styles have been used:

Long quotes: All the names used within this thesis are pseudonyms (refer to Table 3.1 for further information). Pseudonym name and transcript page identify excerpts from participant interviews. All long quotes are in italics, for example:

> *Nursing internationally has evolved, so a nursing leader in Fiji should be able to look outside and see what a major role that nursing in Fiji could take on a par with nursing practice worldwide* (Coral, p.117)

Short quotes: Where excerpts or short quotations are used within the main text, these are specified through the use of quotation marks, for example:

> 'You know, we belong to the Public Service, the government. We belong to the Public Service Commission' (Alice, p.138)

Bold font: The use of bold font occurs within direct participant quotations to indicate emphasis in terms of tone of voice that the participant made.

KEY TO STYLE

1. Where direct quotations are used from referenced sources, this is a deliberate reference to authoritative voices.
2. Direct quotes from the text 'Jonathan Livingston Seagull' (1973) by Richard Bach are in italics.

ABSTRACT

The incidence of adverse clinical events in health care organisations is an international problem. While intense interest has focused on this issue world-wide, with various responses including the introduction of clinical governance in developed countries, it has been less of a focus in developing countries, where the struggle to provide minimal resources for health care is often a priority. In Fiji, with the introduction of health reform funded by international aid agencies, improving patient care is now topical. The role of nurses, and particularly leaders in the nursing profession, is of paramount importance in the goal to provide better and safer health care to communities. Research shows that a key component of the successful implementation of clinical governance is effective clinical leadership. My main interest with this study was about the impact of nursing leadership. While extensive research has been conducted into the impact of nurses on safer care and better health services, this has not yet extended into developing countries such as those in the Western Pacific. There is a gap, therefore, in knowledge about how nursing leadership, and the nursing profession, effects health care policy and practice leading to better patient care in this region.

This critical ethnography set out to expand understanding about the role that nursing leadership has in improving patient care in Fiji. The study pursued the question: 'How does a clinical governance framework contribute to the changing role of nurse leaders in Fiji?' The study had three specific objectives: 1) To undertake a critical literature review of the application of clinical governance principles within both developing and developed countries, with particular emphasis on the impact for nursing leaders; 2) To undertake a study of the evolution of nursing leadership in Fiji; 3) To critically investigate the situation for nurse leaders in Fiji, as the health care system embraced a continuous improvement framework and increased leadership accountability for effective nursing practice.

With the recognition that organisational life is socially constructed and that the nurse leaders functioned within the bureaucratic structure of the Fiji Ministry of Health, social constructionism formed a basis for this research. Taking a critical theory approach with the research proved vital, given Fiji's extensive history of colonization

and the intention that participants had an opportunity for positive social change if they so chose. From a methodological perspective, Carspecken's (1996) five recommended stages for critical qualitative research provided a framework within which the study was conducted, analysed and used to partially explain findings. Habermas's theory of communicative action (1984) comprised the analytical lens through which participant interview data, field notes and various official documents and media reports were explored.

This critical ethnography involved conducting interviews with six nurse leaders in Fiji over a two-year period and extensive time spent with staff of the Fiji Ministry of Health. The participants in this study were all experienced nurse leaders who held senior leadership positions, either in hospitals and community health services, or in the Head Office of the Ministry. During the interviews, participants shared extensive information about what it meant to be a nurse leader in Fiji, and what the impact of clinical governance was having on their professional lives. Attention to postcolonial issues was vital throughout the conduct, analysis and writing up of this research. The participants were all indigenous Fijians and spoke explicitly about the effect of colonization on the nursing profession in that country. I carried a heavy responsibility to appreciate the issues inherent in conducting the research as a non-indigenous researcher.

Analysis from a critical perspective revealed three major themes, which are presented as distinct but related chapters in the thesis. The themes are: Findings our voices: understanding that we are powerful; Legitimizing our role as the facilitators of best patient outcomes; and Recognition of our capacity to take a leading role in health care. Themes are presented from the perspective of the participants' narratives as well as field notes and documents, with my interpretations, based upon the Carspecken methodology and a Habermasian reading of the data. The findings are presented initially from the perspective of the analytic themes and the literature comprehensively reviewed. They are then discussed in terms of the literature identifying a link between effective nursing leadership, nursing conditions and optimum safe patient care.

The recommendations from the study are identified as they emanate from the findings and include those concerning nursing leadership, education, nursing practice and patient care, as well as recommendations for potential further research.

Table of contents

List of tables

Chapter 1

Jonathan's Gift – The Introduction

It was morning, and the new sun sparkled gold across the ripples of a gentle sea. A mile from shore a fishing boat chummed the water, and the word for the Breakfast Flock flashed through the air, till a crowd of a thousand seagulls came to dodge and fight for bits of food. It was another busy day beginning.

But way off alone, out by himself beyond boat and shore, Jonathan Livingston Seagull was practising. A hundred feet in the sky he lowered his webbed feet, lifted his beak, and strained to hold a painful hard twisting curve through his wings. The curve meant that he could fly slowly, and now he slowed until the wind was a whisper in his face, until the ocean stood beneath him. He narrowed his eyes in fierce concentration, held his breath, forced one…single…more…inch…of curve…Then his feathers ruffled, he stalled and fell.

Seagulls, as you know, never falter, never stall. To stall in the air is for them disgrace and dishonour.

But Jonathan Livingston Seagull, unashamed, stretching his wings again in that trembling hard curve – slowing, slowing, and stalling once more – was no ordinary bird.

Most gulls don't bother to learn more than the simple facts of flight – how to get from shore to food and back again. For most gulls, it is not flying that matters, but eating. For this gull, though, it was not eating that mattered, but flight. More than anything else, Jonathan Livingston Seagull loved to fly.

This kind of thinking, he found, is not the way to make one's self popular with other birds. Even his parents were dismayed as Jonathan spent whole days alone, making hundreds of low-level glides, experimenting.

(Bach, 1970)

This iconic text of the 1970s, 'Jonathan Livingston Seagull' by Richard Bach, has been integral to the way I have approached my life, including my professional life, since reading it during my first year of nursing school in 1972. As a prolific reader, I have found other texts have come and gone, but Bach's fable about a bird who transcended norms, who wanted freedom from the oppressive structures of what it meant to be a 'normal' seagull, and who continued to seek this freedom despite

unrelenting obstacles, including exclusion from his family and society, continues to inform my life and work. Jonathan did eventually find his freedom, and became a teacher and mentor to other seagulls so they also could free themselves from oppression, including the limitations they placed upon themselves, so that they could learn new ways to fly. My journey towards being a proponent of critical theory, then, has been an extension of my own life-long philosophy. Jonathan's gift concerning this thesis has been twofold. In one way, the writing of a PhD thesis requires self-imposed exclusion from family and friends; it involves plenty of stalling and falling in flight; it is a lonely journey that eventually ends as merely a beginning of new learning. In other ways, Bach's (1970) story of the little seagull who came to transform the way that others could view their world is reflective of the sort of experiences that researcher and participants can have during the process of critical research. It will become obvious during the reading of this thesis that the participants and I learned different ways of being in our world, that despite obstacles which sometimes meant being excluded by others, we persevered. My intention with this research was to facilitate freedom from oppressive organisational forces through increased reflection and through necessary action. Obviously, as will always happen, my own interpretations of Jonathan's journey and about what happened during the course of the research are going to be there. My aim, nevertheless, was for the voices of participants to soar as Jonathan Livingston Seagull did through the bright blue sky of my voice, so that theirs become the voices that we hear in the reading of this thesis.

Context

The setting for this research is in some ways not dissimilar to Bach's (1970, p. 13) description of sun sparkling "gold across the ripples of a gentle sea". Fiji has long been a popular tourist destination and images of smiling locals, greeting visitors with a cheerful 'M'bula', beside a sun-drenched tropical sea are those that most people not from Fiji are familiar with. In other ways, the Fiji Islands are very different. From the perspective of health care and the health system in Fiji, which is the concern of this research, it is a complex environment.

The Fiji Islands is in fact a republic covering 18,000 square kilometres, with a population of some 814,000 people living on more than 300 islands This particular geography poses major challenges in terms of planning for and delivering health

services to a population living across such a large oceanic region (Ministry of Health, Fiji, 2003). The particular health challenges facing Fiji are not dissimilar to those of the developed world; they include an increasing instance of chronic and degenerative diseases such as diabetes, heart disease, hypertension, stroke and cancer, mental health problems, and communicable diseases such as leptospiroses, HIV/AIDS and sexually transmitted diseases, dengue fever, lymphatic filariases, measles and rubella. The Fiji Ministry of Health also reports increasing levels of trauma, domestic violence and substance abuse, and sporting and diving injuries. Fiji's health sector confronts the same challenge as elsewhere in the world: demand for health services is increasing, and the health budget must accommodate meeting such demand. At the same time, the level of service required is one that provides for both an effective and efficient service for the people of Fiji. Currently, all government health services are funded through general taxation and are free to the public. Fiji is divided into three divisions: Central/Eastern, Western and Northern. Acute services are provided by three divisional hospitals: Colonial War Memorial Hospital in Suva for the Central/Eastern Division, Lautoka Hospital for the Western Division and Labasa Hospital for the Northern Division, as well as a Psychiatric Hospital in Suva. There are also two private hospitals, the Suva based 40-bed general hospital and a small 7-bed Maternity Hospital owned by the Catholic Church. Fiji also has a number of dentists and doctors who work on a fee-for-service basis. In addition to acute curative services, the country prioritises health promotion and disease prevention. In terms of resources, this means that a primary health model also operates, with health centres located throughout the islands. Some health centres may have a doctor in residence and some operate with the services of a nurse practitioner as the primary health professional (Usher, Rabuka, Nadakuitavuki, Tollefson & Luck, 2004).

Fiji also faces a critical shortage of health professionals to provide such a diverse service. Recruitment, training and retention of the health workforce (Ministry of Health, Fiji, 2003) are key issues for the people of Fiji; analysis of the public workforce in the nation for several years to 2003 revealed significant attrition of both medical and nursing personnel. Further challenges include a history of ethnic differences since colonization in 1874 when Indians were recruited to Fiji by the colonists to work in the sugar industry (Robertson & Tamanisau, 1988; Sharpham, 2000). In a country where Indo-Fijians now comprise approximately half the

population of Fiji, ethnic tensions continue to contribute to Fiji's difficulties (Madraiwiwi, 2001). According to Madraiwiwi, however, "…the ethnic differences so often remarked upon by observers and lay people alike are but one aspect of the problem" (2001, p. 7). He cites further issues as being caused by the impact of modernisation and change in the country, and mentions issues between chiefs and commoners, an urban/rural divide and tensions between professional and non-professional people as some of the challenges facing Fiji.

Within such an environment, the necessity for careful planning and execution of health services was paramount. In May of 2003, the Fiji Ministry of Health created a combined role of Director of Nursing and Director of Health System Standards. This introduction provides a critical review of what this new role meant for Fiji, as the country, under the leadership of the Director of Nursing/Director of Health System Standards, began an energetic program of improvements to 'standards' of health care. This study has examined what it meant for the nurse leaders of Fiji as the country introduced a clinical governance framework as a means to improve the planning, delivery and evaluation of health services throughout the island nation. The World Health Organization, AusAID, the International Council of Nurses, and aid agencies in countries as diverse as Japan provided some impetus for this sort of reform, as did the leaders of Fiji health care themselves.

Justifying this research

Health reform is about providing decent and safe health care to communities and the international movement towards achieving such a goal has had a profound impact on Fiji in the last several years. Central to this has been the issue of patient safety and

> in May 2002, the Fifty-fifth World Health Assembly adopted WHA [World Health Alliance] Resolution 55.18, which urged member states [of which Fiji is one] to pay the closest possible attention to the problem of patient safety and to establish and strengthen science-based systems necessary for improving patient safety and the quality of health care. (World Health Organization, 2006a)

Improving health care is complex and nowhere more so than in a developing country like Fiji, where the infrastructure is poorly maintained, basic supplies of medicines and surgical supplies unreliable and the temptation for health professionals to migrate

out to richer countries ever present. In this environment, as the World Health Organization (WHO) has so clearly identified, "without strong and committed leadership the patient safety movement cannot succeed" (World Health Organization, 2006a, p.3). Good health care leadership is the key to effective and safe patient care and nursing leadership obviously vital to the achievement of this goal. Given this, international imperatives include the International Council of Nurses (ICN) development of the Leadership for Change (LCF) program to prepare nurses to provide leadership during the health reform programs being instituted in many developing countries (McMurray, 2003; World Health Organization, 2006c). Described as "…a hands-on teaching programme designed to develop nurses and other health professionals as effective leaders and managers" (World Health Organization, 2006b, p. 13), this has had a significant impact in Fiji, where nurse leaders face the challenge of identifying and enacting just what 'effective' leadership means in their particular setting.

Again, WHO imperatives have proved useful here, where one of the organisation's core functions is identified as "providing leadership on matters crucial to health and engaging in partnerships where joint action is needed" (World Health Organization, 2006e, p.37). For the Fiji health system, such leadership impacts upon the sort of conditions within which front-line workers such as nurses carry out their activities for patients. It has been suggested that "management and supervision have much potential to promote job satisfaction, or, if not done well, to demotivate staff and contribute to their loss" (World Health Organization, 2006d, p.13). Leadership in Fiji comes with particular challenges about motivating staff and retaining them within a health service fraught with difficulties. Problems concerning inadequate supplies and equipment and poor wages exist alongside the potential for nurses and other health workers to migrate to developed countries with better conditions and salaries. The problem of migration out is a constant impediment to health care improvements in developing countries. It is consistently alluded to in international, national and local documents concerning workforce issues (Driu Fong, 2003; World Health Organization, 2006b; World Health Organization, 2006c; Yamanika & Piper, 2005) along with strategies to attempt to stop the flow of skilled health workers out of developing countries like Fiji. Indeed, it has been claimed that

> the magnitude of the health workforce crisis in the world's poorest countries cannot be overstated and requires an urgent, sustained and coordinated response from the international community. (World Health Organization, 2006b, p.12)

Based on the guiding principle that satisfied workers remain in organisations, this coordinated response has been inclusive of solid strategies to attempt to either retain workers, or to persuade them to return to their home countries. The WHO is currently in the process of working closely with the Pacific Community and the Pacific Islands Forum Secretariat as well as other key stakeholders, to formulate a Pacific Code of Practice for the Recruitment of Health Personnel within the Pacific Region (World Health Organization, 2006c), specifically to address the problem of migration of skilled health workers. The issue of effective leadership remains central to such strategies.

Effective healthcare leadership, including nursing leadership, is clearly linked to improving conditions for health care workers, including nurses, so that the most talented and experienced will remain in their home countries to deliver effective health care. Further, the reason for keeping them is so that the goal of improved patient care and patient safety becomes achievable. The Fiji Ministry of Health has introduced clinical governance as a means to achieving all of these goals – providing effective health care leadership, keeping health care workers and delivering safe patient care. The goals are inextricably linked, and none more so than introducing a system of health reform that actually achieves its intended aims. Patient safety remains the central goal and currently

> errors in health care know no geographical boundaries. No country – rich or poor – can claim to have fully come to grips with the problem of patient safety. (World Health Organization, 2006a, p.3)

Further to this, there is every indication that the probability of adverse events is much higher in developing countries than developed ones, where poor infrastructure, problems with medical supplies, drugs, waste management and infection control are made worse by the activities of sometimes poorly educated and unmotivated health care workers (World Health Organization, 2006a). Also, giving patients some say in the planning, delivery and evaluation of health care constitutes yet another crucial component of safer patient care. Alongside effective leadership and motivated workers functioning in good conditions so they stay in their home country, ensuring

patients and consumers have a say is central to the worldwide patient safety movement, including that of Fiji. In keeping with this, the world's first Patients for Patient Safety Workshop occurred in November of 2005, in London (World Health Organization, 2006a), and continues to be supported internationally by the WHO and the International Council of Nurses among others. Simultaneously, a Pacific Plan for Strengthening Regional Cooperation and Integration has been developed (Pacific Islands Forum Secretariat, 2005) and included objectives of good governance and improved health care for the people of the Pacific Island nations.

Local responses to these initiatives occurred in Fiji, with the Fiji Ministry of Health Corporate Plan (Ministry of Health, Fiji, 2003) initially including the minimal strategy "establish quality circles at all levels" (p.17). By 2005, The Strategic Plan 2005 – 2008 (Ministry of Health, Fiji, 2005) included the goal that "By 2008, the Ministry of Health will have established and implemented a quality improvement and risk management framework that results in ongoing improvements in service" (p.11). During the years 2004 – 2007, the Ministry evolved from attempting to implement individual quality improvement projects which lacked comprehensive coordination, to introducing a clinical governance framework; with a major focus on the areas of risk management and customer focus (Stewart, 2004; Stewart, 2005; Stewart, 2006a) as a component of the AusAID funded Fiji Health Sector Improvement Program (Davis, 2005). A clear opportunity existed to provide assistance in all of these endeavours in the Fiji Islands in terms of research concerning health reform aimed at improving health care delivery and patient safety. Nursing was particularly important to this enterprise as Milne (2005) notes:

> Nursing services are the backbone of the health system in Fiji and play major roles across the continuum of care from health promotion and health prevention, through treatment and care to rehabilitation, maintenance and palliative care…significant developments in the last decade have transformed the nursing profession and warrant appropriate recognition both within the nursing profession and more widely in the health system. (p. 76)

In addition, effective nursing leadership has emerged as essential to the patient safety agenda (Thompson, Navarra & Antonson, 2005), and my intention with this research has been to commence a process in the Western Pacific of critically reviewing the role of nurse leaders in Fiji as the clinical governance framework was introduced.

The significance of the research

The significance of this research has already been alluded to. The study has focused on how the introduction of the clinical governance framework contributed to the changing role of nurse leaders in Fiji. The international literature in this area, as has been briefly outlined and will later be comprehensively discussed within the literature review and elsewhere, makes explicit connections between effective nursing leadership, the conditions within which nurses work and their retention in the workforce, and minimising adverse events in health care. In the Western Pacific, including Fiji which is the setting for this study, such constructs were new and identifying issues associated with clinical governance, nursing leadership, the nursing workforce and what is best for the patient enabled the recognition of how national health goals could best be achieved from the nursing perspective. As Jong-wook (World Health Organization, 2006b) pointed out:

> Developing capable, motivated and supported health workers is essential for overcoming bottlenecks to achieve national and global health goals. (p. 3)

Using nurse leaders' knowledge and experiences concerning health reform, such as the introduction of clinical governance, enabled an increased ability to achieve the goal of patient safety *for* Fiji, as local experiences better informed the most appropriate way of implementing such processes in the island nation.

The aims of the research

The overall aim of the research was to answer the question: How does a clinical governance framework contribute to the changing role of nurse leaders in Fiji? The three specific objectives for the study were:

- To undertake a critical literature review of the application of clinical governance principles within developing and developed countries, with particular emphasis on the impact for nursing leaders;
- To undertake a study of the evolution of nursing leadership in Fiji; and
- To critically investigate the situation for the nurse leaders in Fiji, as the health care system embraced a continuous improvement framework and increased leadership accountability for effective nursing practice.

This study represents a milestone for the Western Pacific, where, while clinical governance and nursing leadership have been extensively studied in Western developed countries, Fiji and countries like it are only now emerging as strong participants in the move to an international patient safety agenda.

Explaining the thesis

The review of the literature, which follows this introductory chapter, provides a comprehensive framework within which this research was undertaken, that is, within which the nurse leaders shared their experiences about what it meant to be a nurse leader in Fiji as health reform occurred. An explanation of the history and evolution of clinical governance over the last decade is provided, leading to a review of the significance of good health care leadership for effective clinical governance. The review is then refined to focus on the importance of effective nursing leadership as part of the clinical governance agenda. In particular, an understanding of that which constitutes effective leadership both internationally and in Fiji is closely tied to nursing leadership. How nursing leadership links with nursing conditions and thus patient safety highlights the significance of effective nursing care for good patient care.

How clinical governance relates to the Fiji Islands is also discussed, with a focus on the problems of nurse migration out of Fiji. The place of women in Fiji society is explored, both historically and currently, as the majority of nurses in Fiji are women. The issue of being a contemporary nursing leader in Fiji is then linked to traditional ideas of the place of nurses and particularly emerging young nurse leaders in Fiji nursing today. Finally, the issues of postcolonialism and decolonizing research are explored, with reference to this study with indigenous participants.

Chapter 3 discusses the interpretive framework, methodology and method for this study, explaining why a qualitative critical ethnography was chosen for the research. The nurse leaders of Fiji carry out their professional activities as members of the organisation which is the Fiji Ministry of Health. Thus, I took a social constructionist viewpoint within the research, given that those who function within organisations are inevitably constructed by the social, historical and cultural norms and values within an organisation (Schwandt, 2003). Further, critical ethnography,

while retaining the aim of rich description about what is going on, also enables the use of such knowledge for social change (Thomas, 1993). The methodology used involved Carspecken's (1996) five recommended stages for critical qualitative research, those of compiling the primary record; preliminary reconstructive analysis; dialogical data generation; describing systems relations; and systems relations as an explanation of findings. Habermas's (1984) theory of communicative action then constituted the lens within which analysis of the data was undertaken. His notions of 'lifeworld' and 'system' as constituting society were imperative, as were the problems involved when system colonizes lifeworld. In organisational life, it was important to reflect upon those circumstances where strategic communication might overtake the 'ideal speech situation' and where strategising can result in alienating problems for human actors. Edgar (2006, p.65) refers to Habermas's reconstruction of the 'ideal speech situation' to that of the 'unrestricted communication community'. The basic tenet of this concept remains consistent, however, and will be fully explored in Chapter three. As Edgar (2006, p. 67) points out, the notion of an ideal speech situation/unrestricted communication community is about Habermas's criticising of

> not just imperfections in scientific debate and inquiry, but also imperfections in moral, political and legal debate, again precisely because actual debates will systematically exclude certain people, or inhibit the raising of certain complaints or topics. The notion of an ideal speech situation explains why this state of affairs is morally and politically wrong.

Such a lens was an extremely useful perspective within which to analyse the activities of a health care system, where the exclusion of particular voices - such as those of nurses and patients - from debate about health care policy, planning, delivery and evaluation was found to affect health outcomes.

The analysis and findings Chapters 4, 5 and 6 are based upon the three major themes that emerged from the study. They provide comprehensive explanations about how Carspecken's methodology and the Habermasian lens provided the opportunity to analyse what the participants were saying, what was happening at the time in the Ministry and what I was seeing and reflecting upon myself.

Chapter four has the major theme and title: 'Finding our voices: Understanding that we are powerful'. Empirical findings within this chapter include the nurse leaders' recognition that Western colonization and influence had both adverse and favourable effects on Fiji nursing. Also, the introduction of the clinical governance framework

had facilitated an opportunity for them have a greater voice in health policy development in the Fiji Ministry of Health. This had occurred in part through increased opportunities for education with the doctors, as multidisciplinary education proved to be a vehicle for increased empowerment for the participants. Of interest also was the finding that traditional ideas of nurses having to wait until relative middle-age before achieving leadership positions was being questioned with participants generally favouring increased opportunities for young talented nurse leaders. Ideas of increased empowerment were then linked to a recognition by the nurse leaders that they could dispense with a general tradition of nursing passivity and make their own decisions about health services in Fiji.

Chapter 5: 'Legitimizing our role as the facilitators of best patient outcomes' continues this theme of empowerment for the participants but also links the theme with an increased understanding of the difficult conditions within which front-line nurses do their work. The Habermasian reading of participants' stories then enabled the finding that although the nurse leaders understood the complexities of improving nursing conditions in Fiji, their intention was to work toward achieving this aim. A link between improved nursing conditions and better patient care was then made with the nurse leaders reflecting upon how safer patient care meant giving not only the front-line nurses, but also the patients, a voice in the health system.

Chapter 6: 'Recognition of our capacity to take a leading role in health care' focuses on the nurse leaders' initial sense of loss as members of a 'nursing group' and as they renegotiated their place as part of a multidisciplinary team of health professionals focusing on the patient. Barriers to their ability to take a leading role in health care were also identified and these included resistance to their leadership by medical colleagues, a history of poor communication throughout the Ministry, and the vital issue of migration of nurses out of Fiji. The role of the nurse leader from an international perspective was of particular importance as the nurse leaders reflected upon their desire to be considered effective nurse leaders in the international arena. Finally, their intention to take a key leadership role in the improvement of health services throughout the Fiji Islands was identified as they linked an increased sense of empowerment with the ability to take corrective action for health reform.

Chapter 7 extends the information from the analysis and findings chapters and comprises a comprehensive discussion concerning how the nurse leaders might renegotiate their place in the Fiji Ministry of Health. Findings are compared with existing literature and significant new findings highlighted in terms of their possible impact within the Fiji Ministry of Health. The three major themes are continued throughout this chapter as both enabling and inhibiting factors are discussed in terms of the possibilities or otherwise of necessary social change for the nurse leaders, the front-line nurses and the patients of the health care system.

Chapter 8 is the final chapter for this thesis and draws together the findings and ways that these are linked to recommendations. Recommendations for health policy development, for nursing practice, for education as well as the potential for further research are made, based upon the conclusions from this study. Strengths and limitations of the study are outlined as well as an overview of the researcher's role.

We turn now to a more comprehensive review of the literature which will further inform the justification for and the significance of this study.

Chapter 2

A review of the literature

The trick, Fletcher, is that we
are trying to overcome our limitations in order,
patiently.
We don't tackle flying through rock
until a little later in the programme
(Bach, 1970, p.86).

Introduction

Delivering a good quality of health service has long been promoted as a concern for health practitioners. However, it is only in the wake of a number of crises in the late twentieth century that the scope of the problem concerning poor service has been properly highlighted. Since the Bristol enquiry into abysmal childrens' heart surgery outcomes in the United Kingdom and the Australian Quality in Health Care Study at the latter part of the 20th century revealed inadequacies in local health services, there has been an immense body of research investigating the various impacts of poor health services on communities internationally. In addition, much scholarly writing has appeared exhorting health practitioners to improve services, attempting to explain various reasons for adverse patient outcomes and offering complex solutions for improving patient services. Clinical governance has emerged as a major framework for necessary improvement.

The nursing profession has made a significant contribution to this literature. There is a large body of research investigating the contribution or otherwise of nurses to adequate and safe patient care, with considerable focus on the links between conditions for nurses and the sort of nursing care that is provided. Importantly, this includes literature about nursing leadership, particularly the role of nurse leaders in improving conditions for nurses and thus patient care. Such literature is highlighted in this review.

While affluent Western countries have been grappling with the problem of providing effective health care, developing countries struggle with such basic public health

concerns as safe drinking water and adequate sanitation. At the same time, stimulated by funding from international aid agencies, developing countries have commenced a process of enhancing hospital and community health services. There is an emerging literature in this area, in terms international reports such of those of the World Health Organization, research findings and theoretical writings about these efforts, with links made to similar health care improvement strategies in developed countries. This literature features prominently throughout this thesis and serves to further justify the study.

In the 'developing' country of Fiji, which is the context for this particular study, the contribution of nurses to effective health care is beginning to receive some attention. Those elements that impact on Fiji nursing and thus patient care are inclusive of the traditional cultural world of Fiji; a history of the adverse effect of colonization; the postcolonial place that is Fiji society today; and, importantly, the historical and contemporary place of women in the world of Fiji (given that the majority of nurses in Fiji are women). This review, while aiming to discuss and critique the literature on relatively recent attempts at improvements to health services internationally, provides a specific focus on the role of nurse leaders and nurses in such improvements. In order to better explain the particular situation in Fiji in terms of the wider social, cultural and political context for nurses in that country, this review also discusses the role of women and leadership in Fiji, and nursing leadership in the island nation.

This literature review has been undertaken using a myriad of resources including the databases ProQuest 5000, Ingenta, PsycINFO, Medline and CINAHL. The James Cook University library e-journals were a major source; the Townsville Hospital library and other Australian libraries were utilised through the interlibrary loan scheme. Google and Google Scholar search engines were used as leads to other sources and government reports were also utilised. Key words and phrases used when searching for information included: clinical governance; clinical governance and nursing leadership; clinical governance and nursing; nursing and patient safety; nursing and Fiji; patient safety and Fiji; clinical governance and Fiji; nursing leadership and Fiji. As the research proceeded, the review was extended to include the key phrases postcolonialism and Fiji and critical management studies and Fiji.

The literature incorporates a review of the clinical governance literature, identifying the pivotal role of effective health care leadership, particularly nursing leadership, to the success of clinical governance. Consistent with this, a review of the literature pertaining to women and leadership in Fiji, with a focus on nursing leadership, as has been mentioned, is emphasized.

The intention of this study was to explore how the introduction of the clinical governance framework contributed to the changing role of nurse leaders in Fiji. It was not intended to explore all aspects of clinical governance and health care, rather, the focus was on the experience of the nurse leaders as clinical governance was introduced in Fiji. Therefore, the literature review does not include the entire international literature currently available about clinical governance, but instead focuses on clinical governance and nursing leadership. The review commences with an overview and explanation about clinical governance, to provide a context within which this study took place. This provides a framework within which to discuss the importance of good leadership for effective clinical governance. The review has emphasised the major studies and theoretical literature, highlighting current developments in the area of improved patient care, and has been constructed around seven major topics. The following table provides a justification for the components of this literature review:

Table 2.1: Literature review – components

Topic	**Rationale**
Clinical governance	Provides the context within which this particular study took place
Leadership and clinical governance	Highlights the crucial role of leadership for effective clinical governance
Nursing leadership and clinical governance	Provides a focus for the impact of nursing leadership on safe and effective patient care
Clinical governance and Fiji	Provides a local context for this particular study concerning aspects of clinical governance
Women and leadership in Fiji	Explores the literature concerning traditional Fijian leadership, the place of women in Fiji society, and the

	effects of colonization in Fiji to provide a specific context for study participants
Nursing leadership in Fiji	Provides a focus on the importance of clinical governance as a potential vehicle for enhanced nursing leadership in Fiji
Postcolonialism and decolonizing research	Emphasises the challenges inherent in conducting research with indigenous participants

Method

Inclusion criteria for the review were established with my supervisors. Criteria were reflective of the need to later establish congruence between nursing leadership, clinical governance and safe patient care within the context of Fiji culture and the Fiji health system. Inclusion criteria involved studies from a range of methodological approaches as well as scholarly opinion pieces, current texts and government reports which pertained to patient safety and the Fiji health system. Regarding clinical governance, the inclusion date was from 1998, when clinical governance was introduced in the United Kingdom. Given the myriad of literature, the decision was made to include seminal papers as well as a broad selection of work from the nursing, medical and health care management literature. The review was extended to include American and other international literature concerning quality improvement and patient safety, particularly where a relationship was promoted or established regarding the impact of nursing leadership on patient safety. Exclusion criteria involved literature which reproduced similar concepts or findings so that 'saturation' was achieved involving new information.

The literature concerning Fiji culture and the Fiji health systems remains limited. Therefore, inclusion criteria for Fiji concerned, particularly, texts from Fiji locals and others which provide rich information about local culture. Given the paucity of literature concerning Fiji, the review is also inclusive of 18 reports and government documents that better inform the situation regarding health care and nursing/nursing leadership in Fiji.

The nursing leadership literature is inclusive of classic works since the middle of the 20th century when the scientific study of leadership began, as well as international literature concerning nursing leadership. Once again, studies involving a variety of methodological approaches, scholarly opinion pieces and contemporary nursing texts were included. Postcolonial literature is similarly inclusive of the classic literature from the last century as well as contemporary nursing and other postcolonial theory. The quality of the literature relates to the myriad sources from the international literature regarding the major foci for this study, with exclusion generally being from the point of 'saturation' rather than methodological concerns. The aim with this literature review, as has been stated, was to provide a comprehensive picture of the major foci and at the same time establish congruence between them.

Within this review, the dominant themes in the literature concerning the provision of safe and effective health care are highlighted, with a particular emphasis, as has been explained, on what this means for Fiji and Fiji's nurse leaders. In the process of critiquing the literature, the gaps in knowledge about what a system of improving patient care (the clinical governance framework) would mean for Fiji's nurse leaders in particular, emerged. These gaps provide a basis for the ensuing discussion about a changing nurse leadership role in Fiji.

Clinical governance

In the final decades of the last century, it became obvious that the burgeoning costs of health care had contributed to health care leaders becoming too financially focused, with consequent serious clinical failures (Scally & Donaldson, 1998). In the years 1998 – 2007, many conceptual articles, texts, and several research studies, particularly from the United Kingdom, have emerged about the response to this perceived crisis in health care. Cases such as the Bristol enquiry (Learning from Bristol: the report of the public inquiry into childrens' heart surgery at the Bristol Royal Infirmary 1984 – 1995, July 2001) provided the impetus for the British Government to plan radical change to the ways in which health services were managed and health care was delivered. The response was to develop an agenda where the quality of the health care delivered to patients was to be as important as meeting organisational targets and staying within budget. This response was to introduce 'clinical governance', which is "a system through which …organizations are accountable for continuously improving

the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (Scally & Donaldson, 1998, p. 2). Much of the literature about clinical governance over the ensuing years has focused on how to translate this ideal into the practicalities of care delivery. The World Health Organization has identified four central principles relating to the quality of care delivery which have remained central to the clinical governance agenda. These are: professional performance (about the technical quality of care); resource use (about efficiency); risk management (about the risk of illness or injury associated with the provision of service) and consumer satisfaction with the service delivered (Wilkinson, Rushmer & Davies, 2004). Within these principles, writers and researchers have attempted to describe elements necessary in order to implement clinical governance. As Swage (2004) so clearly notes, clinical governance is not a new notion but rather a framework upon which to base quality initiatives.

Key components

The key components of good clinical governance which have been widely discussed are effective clinical leadership (Bayliss, Hill, Calman & Hamilton, 2001; Degeling, Maxwell, Iedema & Hunter, 2004; Firth-Cozens, 1999; Nicholls, Cullen, O'Neill & Halligan, 2000; Scally & Donaldson, 1998); the need for a team or multidisciplinary approach to health care planning, delivery and evaluation (Currie & Loftus-Hills, 2002; Ferguson, 2002; Firth-Cozens, 1999; Heard, Fergie, McCready Hall, Schiller & Aitken, 2001; Nicholls et al., 2000; Sanderson, 2000); and the ability to achieve cultural and behavioural change within organisations (McSherry & Pearce, 2002; Nicholls et al., 2000; Ovretveit, 1999; Pickering & Thompson, 2003; Scally & Donaldson, 1998; Swage, 2004). While the clinical governance literature identifies these and other components as necessary in order to deliver effective health care, given the spotlight on nursing leadership and clinical governance in this study, the literature which centres on effective clinical leadership will be the focus for this review.

Leadership and Clinical Governance

Scally and Donaldson (1998) make the claim that achieving successful clinical governance will occur only through good leadership and commitment from those who control organizations. Nurses are not identified as leaders in this scholarly article.

Instead there is instead intimation that clinical managers are doctors and nursing is not specifically mentioned, although there are general references to 'managers and health professionals'. This is probably in response to the Bristol case and a focus on doctor errors, although the Bristol inquiry did note that an absence of paediatric nurses influenced the adverse outcomes at Bristol. Martell (1999, p.8) on the other hand cites England's chief nurse, Dame Yvonne Moores as claiming that it is *nursing* leadership that is uniquely placed to take the lead in the clinical governance agenda. Firth-Cozens (1999) is rather more inclusive, urging that the best person should be chosen for the job of leading the clinical governance agenda within an organisation, rather than considering specific professions or job titles. Nicholls, Cullen, O'Neill and Halligan (2000) are more concerned with what leadership means within a healthcare setting, stating that leadership must be about having an understanding of the current reality in health care as well as having followers committed to a vision for the future of health care delivery. For Franks (2001), developing good clinical leadership is a key 'content' area for clinical governance. A qualitative study by Currie and Loftus-Hill (2002), involving discussion groups with nurses around the topic of clinical governance, found that the support of effective managers and leaders led to more empowerment for nurses and better patient outcomes. This finding is supported by the work of Grainger, Hopkinson, Barrett, Campbell, Chittenden, Griffiths, Low, Parker, Ashok, Thompson and Wilson (2002), who conducted their cross-sectional qualitative study in the West Midlands Region of the United Kingdom. These researchers conducted one-on-one interviews with the CEO, Medical Director, Nursing Director and others 'as appropriate' (Grainger et al., 2002). It would have been useful for the researchers to have further explained just who the 'appropriate others' were, and how they were chosen for these interviews. The researchers also note that they visited as many departments as they could to speak to staff. Once again, which departments were included and which departments were not and the reasons why, would have been helpful to know. Nevertheless, their findings did include information about the absolute necessity for clear and effective clinical and managerial leadership if organisations were to progress well with the clinical governance agenda.

Time and education

Lewis, Saunders and Fenton (2002) take an interesting slant on the issue, claiming that initially in the United Kingdom, there were not *enough* leaders appointed to co-ordinate all the elements of clinical governance. For these authors, resource allocation in relation to having a formal leader for each element of clinical governance within an organisation is necessary in order to contribute to successful outcomes. Resource issues have also been highlighted by Hedley, Fennell, Wall and Cullen (2003), although their scholarly article is about providing 'protected time' for both clinicians and managers to learn about clinical governance, and to analyse their particular organisation and develop action plans for improvement. The authors developed a three-day program to enable these objectives to be progressed and discuss various strategies and patient outcomes which evolved from 'protected time'. Educating for leadership has also received some attention in the literature, with Boggust, Deighan, Cullen and Halligan (2002) identifying the need for senior management personnel to be taught to become more 'personally involved' in order to put into place an organisation-wide approach to clinical governance. Clark and Smith (2002) describe their qualitative study concerning the relationship between the development of clinical governance and education in primary health care, where primary health care managers required education to become more competent in both strategic thinking and good management. Williamson's (2005) study concerning the need to provide 'protected time' to work-based learning further supports these findings. Although Degeling, Maxwell, Iedema and Hunter (2004) also clearly support the necessity for excellent health care leadership, their concerns are that such leadership must be provided by clinicians, and that the best model for clinical governance would be one that "…invites the people who do the work to define, describe, assess and manage what they do as teams" (Degeling et al., 2004, p.681). Such concerns are supported by Freeman's (2003) study, where a strongly negative association was found between a centralized hierarchical structure and clinical governance climate. The idea is that good clinical governance would be co-ordinated by good clinical leaders, rather than by centralized control from bureaucratic administrators in executive positions in healthcare organizations.

Nursing leadership and clinical governance

Effective nursing leadership

Consistent with the view that a multidisciplinary focus for clinical governance is essential, there is currently a developing literature specifically addressing the issue of nursing leadership and clinical governance. Currie and Loftus-Hill (2002) provide a useful summary concerning the United Kingdom Royal College of Nursing engagement of its membership in the clinical governance agenda. There is an enormous literature related to nursing leadership, for example, Iriruta's (1996) extremely useful study and more recently Daly, Speedy and Jackson's (2004) definitive text. In addition, extensive writing and research concerning nursing and quality assurance exists, for example, Gallagher and Rowell (2003) and Caraminca, Cousino and Peterson (2003). While this review focuses on the relationship between clinical governance and nursing leadership, there is a need to preface this with reference to current notions of effective and ineffective leadership in organizations like health care systems. The subject of just what it is that constitutes effective leadership, including nursing leadership, has an enormous literature, with studies over time often providing contradictory advice to aspiring leaders.

Kouzes and Posner's (2002) definitive research over nearly two decades has provided a handy review of the changing 'face' of leadership. Nevertheless, they continue to find four characteristics that others rate the most admired in leaders, those of being honest, being forward-looking or visionary, being competent in their work, and being inspirational. Covey (2004) found similar characteristics rated as desirable in leaders, the top four being those of having integrity, being a good communicator, being people focused, and being visionary. Cameron and Masterton (2000) contend that, despite a view that "the phenomenon of leadership is one of the most extensively researched of all social processes" (p. 1082), what good leadership means often remains confusing.

Leadership in the 20th and 21st centuries

To provide a background to current thinking about leadership, it is useful to briefly consider the evolution of leadership theory since it began as a topic of scientific study in the 20th century (Marquis & Huston, 2006). This provides some indication about why leaders might behave the way they do in leadership positions, given the social constructedness of such roles. It is also vital to make some distinction between the

terms ‘leader’ and ‘manager’ as defining these is a continuing source of debate among theorists regarding the differences and similarities between leadership and management (Courtney, Nash & Thornton, 2004). It should be noted, with reference to this review and elsewhere, that the term ‘nurse leader’ has been used throughout this study to describe participants. These are individuals who are in formal positions of authority in the Fiji Ministry of Health (although informal leadership obviously also occurs within groups). While they do undertake management functions such as planning, budgeting, organising and staffing, their major focus is, as Kelly-Heidenthal (2003) indicates in terms of leadership, to lead change in terms of “establishing a direction, aligning people through empowerment, and motivating and inspiring them toward producing useful change and achieving the vision” (Kotter, 1990, cited in Kelly-Heidenthal, 2003, p. 167). The evolution of leadership theory has progressed through early ‘great man’ (sic) theories until the 1940s, to current ‘transformational’ leadership theory (Courtney, Nash & Thornton, 2004; Kelly-Heidenthal, 2003; Marquis & Huston, 2006; Yoder-Wise, 2003). Importantly, the study of leadership has been criticised as being

> traditionally focused too narrowly on a limited set of elements, primarily highlighting the leader yet overlooking many other potentially relevant elements of leadership such as follower and context.(Avolio, 2007, p.25)

Such criticism is most reflective of early ‘great man’ or ‘trait’ theories, which were essentially about innate qualities that individuals were said to possess so that they were, in effect, ‘born to lead’. As Horner (1997) points out, such theories did ignore environmental and situational factors that influence leader effectiveness. Later work, including that of Lewin (1951) and White and Lippitt (1960) into the now commonly known styles of autocratic or authoritarian, democratic and laissez-faire leadership commenced a process of considering both context and leader in their studies. Such behavioural theories spawned a range of behavioural and contingency leadership theories, including those of Fiedler (1967), Hersey and Blanchard (1969) and Vroom and Yetton (1973) which examined in a range of different ways and with various foci, as Avolio (2007) points out, the links between who the leader was and what he or she said or did, who followers were and what they said or did and the organisation within which they all functioned. More recent models which have emerged are concerned with the leadership factors identified in Bass’s (1985) research about leaders being somewhat transformational, or being transactional, or not leading at all. While such

studies of transformational leadership are not without problems, particularly in the context of a developing country like Fiji, they provide a useful framework within which to consider contemporary leadership. Blunt and Jones (1997) have raised concerns that notions of transformational leadership are essentially Western and more precisely, North American, and are potentially problematic in developing countries where they may contravene collectivist rather than individualist notions of leadership success in organisations. Further, Wielkiewicz and Stelzner (2005) voice objection to the 'industrial' paradigm which they claim informs current leadership theory. While such doubt should continue to be part of the study of leadership, the current focus on transformational leadership in terms of potential positive transformation of organisations remains useful.

Effective leadership

Having said this, this review focuses on those attributes that Kouzes and Posner's (2002) twenty years of research have found most effective for leaders. These characteristics are indicative of leaders who are said to be 'transformational' (Bass & Avolio, 1994; Kuhnert, 1994) and transformational leadership, according to Sofarelli and Brown (1998), is essential for the future of nursing. A useful framework within which to consider transformational leadership has been provided by Bennis (1989), who described four competencies for leadership effectiveness. These are "management of attention; management of meaning; management of trust; and management of self" (p.19). 'Management of attention' is about having a clear vision for the future of an organization and structuring activities around that vision. Visionary leadership has been found as consistently significant for effective organizations (Fedoruk & Pincombe, 2000; Kouzes & Posner, 2002). 'Managing meaning' is concerned with being able to communicate the vision or preferred future in ways that inspire others to share the leader's goals. Alarcon, Astudillo, Barrios and Rivas (2002) found, in their study of nursing leadership in Chile, that those with the ability to involve others in a vision in the long-term were believed to be the most effective nurse leaders. 'Managing trust' means being trustworthy and Sofarelli and Brown (1998) point out that this "indicates that leaders are totally reliable and their actions have integrity" (p.204). These nursing authors also make links between trustworthiness and connection with, or high visibility to, those who follow them. 'Management of self' as Bennis describes it has similarities to Goleman, Boyatzis and

McKee's (2002) notion of the emotionally intelligent/competent leader. Here, the leader exemplifies excellent knowledge about themselves and is able to then use their known skills effectively. Effective leadership in this sense is clearly linked to developing increased self-confidence as the leader's awareness of their strengths and weaknesses provides a platform for overcoming the latter. Chan's (2002) study of effective nursing leadership in Hong Kong is illuminating here, where she found that issues around medical domination served to decrease nurse leader self-assurance.

A review of both the general and nursing literature continues the theme of 'transformational leadership'. Whether considering Senge's (1992) notion of leadership within a learning organization (Prewitt, 2003); or Goleman et al.'s (2002) consideration of the emotionally intelligent/competent leader (Langley, 2000; Rozell, Pettijohn & Parker, 2001; Sosik & Megerian, 1999), the idea of the visionary, motivational, consistent and self-aware leader emerges as vital for the successful organization. Such transformational leadership behaviour is said to decrease follower burnout (Kanter, 1993; Stordeur, D'hoore & Vandenberghe, 2001), contributing to better outcomes for both personnel and customers or clients of an organization. Indeed, the opposite of burnout could be empowerment and the link between transformational leadership and empowerment of followers (Sofarelli & Brown, 1998), provides some clue to the link between effective nursing leadership and better outcomes for both nurses and patients. Indeed, Kanter (1993, p.294) notes that "concepts, such as 'empowerment' have become the cornerstone of movements to improve quality and service in numerous industries". At the same time, as Fletcher (2006, p.58) reminds us,

> there is …a danger of appearing to minimize the vast literature that offers much to our understanding of image, empowerment and leadership by becoming too narrow or simplistic.

Nursing leaders and empowerment

Yet, nurse leaders may well be transformational, but be constrained by the organizational structure within which they function. Kanter's (1993) proposition was that it is the structure of the organization that often determines the behaviour of employees, and this is no different for nurse leaders. Fletcher (2006) contends that "nurses work in patriarchal medical institutions, controlled by men" (p.52) and that effective nursing leadership is only possible through reflection upon the oppressive forces within health care organizations so that they may be overcome. This is

consistent with the transformational leadership idea of self-knowledge, but this knowledge of self, or self-awareness, must be part of a wider understanding of oppressive forces that work against even the best of transformational nurse leaders, so that the rhetoric of empowerment can become an increasing reality. For Shirey (2004, p.315), "much of the benefit from empowerment appears to come from access to information, knowledge transfer, and close personal relationships that enhance an individual's psyche". The issue is that nurse leaders need access to that information themselves so they can share it with followers, and that this can only occur through overcoming oppression within the organizational structure of the health care system.

Nursing leadership and patient safety

There is a developing body of literature concerning nursing practice and elements of clinical governance, particularly risk management, where a discourse around the topic of 'patient safety' is emerging as a key theme for nursing. Risk management in this context is about identifying, assessing and reducing risks in health care organisations (Sale, 2005; Vincent, 2001). In terms of nursing leadership and patient safety, Thompson, Navarra and Antonson (2005, p.331) ask the crucial question: "…how can we isolate the unique challenges nurses face as leaders trying to advance a patient safety agenda in their practice environments?" A study involving the impact of introducing clinical governance on the role of the nurse leaders in Fiji requires a consideration of the impact of effective and ineffective nursing leadership from a global perspective.

The Western Pacific

Justification for clinical governance in Fiji is clear, given the various reports that have emanated from the World Health Organization (WHO) over the last several years. As has been discussed in Chapter 1 of this thesis, the WHO continues to release documents and recommendations identifying current health and health management problems in developing countries (World Health Organization, 2005a; World Health Organization Regional Office for the Western Pacific, 2005; World Health Organization, 2006a; World Health Organization, 2006b; World Health Organization, 2006c; World Health Organization, 2006d; World Health Organization, 2006e). For example, it has been noted that

> the starting point for addressing the challenges facing health systems has been to define the elements of a clear and actionable agenda which recognizes and responds to current system underperformance and acknowledge that success depends on a range of factors in wider society. (World Health Organization, 2006e, p.3)

This range of factors is clearly inclusive of the sort of leadership, including nursing leadership, on offer in particular health systems. Links between good leadership and effective clinical governance are consistently alluded to not only by the WHO, but by more local organisations such as the Pacific Islands Forum Secretariat (2005), where the key objective of 'improved health' for Pacific island nations is linked to appropriate health care leadership. Issues that impact on clinical governance, and which will be comprehensively addressed in this thesis, are inclusive of nursing leadership skills, the conditions within which nurses work and the availability of nurses to do the work, which is in turn influenced by migration patterns and retirement patterns of existing nurses. Migration of nurses out of countries like Fiji, as will be discussed further, has been identified as a significant problem (WHO, 2005a; WHO, 2006b; WHO, 2006c) and retirement of health professionals without sufficient succession planning (WHO, 2006b) only exacerbates workforce shortage. Good leadership is promoted as a key feature of addressing such issues. For example, The International Council of Nurses Leadership for Change Program (WHO, 2006a; WHO, 2006c) has been rolled out in the Western Pacific to function "as a hands-on teaching programme designed to develop nurses and other health professionals as effective leaders and managers" (WHO, 2006c). Effective nursing leadership is then notably linked to enhancing patient safety and providing for an increased patient say in health care planning, delivery and evaluation (WHO, 2006a; WHO, 2006d). Clearly, nursing leadership as this relates to all aspects of clinical governance is vitally important for Fiji and elsewhere.

Having said this, it has been strongly suggested that nurse leaders are the key to recruiting and retaining nurses in organizations (Gantz, Sorenson & Howard, 2003; McPhee, Ellis & Sanchez, 2006; Thompson, Navarra & Antonson, 2005). Further, the link between good nursing conditions and safer patient care has been clearly demonstrated (Aiken, Clarke, Sloane, Sochalski & Silber, 2002). Focus on patient safety also implies a general focus on the customer, or patient; the recipient of health care. The literature about ensuring such a customer focus in health care organisations

is informative, and includes the need to pay attention to customer feedback about staff attitudes as well as the technological aspects of patient care (Bondas, 2003; Darby & Daniel, 1999; Hyrkas, Pauonen & Laippala, 2000; Squire, Greco, O'Hagan, Dickinson & Wall, 2006).

Interest in nursing leadership and clinical governance, with a particular focus on patient safety emerged, for example in Australia, as a result of the Quality in Health Care Study (Wilson, Runciman, Gibberd, Harrisons, Newby & Hamilton, 1995) and a number of crucial inquiries into adverse events for patients throughout the country. The most sensationalised of these have been major enquiries into obstetric and gynaecological services at the King Edward Memorial Hospital in Western Australia and the activities of surgeon Jayat Patel at the Bundaberg Hospital in Queensland. It is clear that good leadership is vital regarding patient safety, with Sheahan, Duke and Nugent (2007) pointing out the various responses that nursing leadership in Australia has undertaken in order to advance the clinical governance agenda. These are said to be "leadership activities at regulatory, organisational and individual levels" (Sheahan et al., 2007, p.28) and include a national review of nursing education, collaborative efforts between health services and academia and increased reporting of adverse events at the level of the individual nurse.

Empowered nurses

From a global perspective, a major focus for nurse leaders has been on empowerment of the nursing workforce. It is apparent that empowered nurses provide better care to their patients, and empowered nurses stay in workplaces rather than adding to problems of retention (Collier & Esteban, 2000; Lewis & Urmston, 2000; Smetzer & Navarra, 2007; Williamson, 2005). One may ask what an empowered nursing workforce would look like and Lewis and Urmston (2000) provide some clue, with their reference to organisations that work to foster good self-esteem and coping skills for individual nurses. Clearly, there is a role for nurse leaders in promoting staff satisfaction through the sort of leadership they provide. Balding (2005, p.355) points out that "quality improvement has long been perceived as 'the top telling the middle what to do at the bottom', which is a far cry from the empowered and participative model required to fulfil the intent and requirements of clinical governance". In order to provide safer patient care, nurse leaders must understand the conditions within

which nurses do their work and they must strive to amend adverse conditions or situations where overworked, disempowered nurses make mistakes and endanger patients.

Nursing conditions

Nursing conditions have been found to have a direct impact on patient outcomes. The elements of nursing conditions include nurse staffing numbers, hours of work, complexity of nursing work, the physical environment of the workplace, treatment by leaders including punishment and blame for problems, the way in which mistakes are analysed, and the quality of teamwork (Aiken, 2001; Aiken et al., 2001; Aiken, 2006; Kalish & Aebersold, 2006; Maddock, Kralik & Smith, 2006; Rogers, Hwang, Scott, Aiken & Dinges, 2004; White, Pringle, Doran & Hall, 2005). Such discussion is vital, because if nurses are going to be empowered to deliver safer patient care, then we need first to take the advice given by Spilsbury and Meyer (2001, p.6) that "vague notions of empowerment, enablement and holistic care cannot sustain a profession". Instead, solid review of the organizational context concerning nursing work as it is linked to patient care is required, and organizational context is always going to include the sort of nursing leadership on offer in a particular organization. Although the abundance of literature around clinical governance and indeed, aspects of clinical governance and nursing leadership, is nearly unmanageable, given the volume that continues to appear since clinical governance was introduced in the United Kingdom (Maddock, Kralik & Smith, 2006), the consistency of studies linking good nursing leadership to good nursing care and consequently, safer patient care, is unquestionable. Aiken (2001) and her colleagues have now spent nearly two decades researching the impact of nursing on patient care. In 2001 she said that "the organizational climate in which care takes place is as important as staffing in determining patient outcomes" (p.224).

As has been mentioned, organizational climate is inclusive of the sort of nursing leadership that is happening. As Thompson et al. (2005, p.331) argue:

> Leading an organization-wide patient safety effort requires nurse executives to couple exceptional leadership with a keen focus on patient safety. They must approach the challenge from a systems perspective while leveraging the voice of the bedside nurse – the voice of a strong patient advocate and of someone who understands how to work as part of a care team.

Exceptional leadership moves away from the traditional hierarchical leadership that has permeated health care organizations for decades. Instead, transformational nurse leaders work to communicate openly with nurses and share both the responsibility and the power to reform health care organizations into places of safety for patient care. The notion of 'shared governance', where nurses are empowered through a move away from traditional, hierarchical styles of nursing management (Williamson, 2005), is the way forward for better care.

Aiken et al. (2001) reviewed hospital care across five countries (the United States, Canada, England, Scotland and Germany) in their crucial study and found that effective nursing leadership is a key indicator for nurses in the provision of safe, high quality patient care. Nurses in the 700 hospitals studied wanted shared governance and "more communication with management about the allocation of resources and the creation of an environment that is conducive to high-quality care" (p. 51). Dissatisfied nurses who planned to leave their hospital jobs were doing so because of core problems in workforce management, including reductions in front-line nurse leadership roles. A further study of 210 hospitals in the United States (Aiken et al., 2002) revealed that "burnout and dissatisfaction predict nurses' intentions to leave their current jobs within a year" (p.1992).

Clinical governance and Fiji

There is generally an absence of published literature concerning clinical governance in the Fiji Islands. However, as has been discussed in Chapter 1 of this thesis, there is a variety of information available, both in government reports and unpublished manuscripts as well as on the Internet, concerning Fiji's plans for an improved health care service. The Minister for Health identifies the Ministry of Health Strategic Plan for 2005 – 2008 as having a Vision of: "A strengthened divisional health structure supporting a well financed health care delivery system that fosters good health and wellbeing" (August 2, 2004, Retrieved January 7, 2005 from http://www.fiji.gov.fj). The Ministry of Health introduced a Clinical Governance/Quality framework for health services (Stewart, October, 2004), in which the Director of Nursing/Director of Health System Standards played a pivotal leadership role. The literature concerning this initiative is largely in the area of unpublished Ministry of Health reports (Stewart,

2005; Stewart, 2006) at the time of writing, although it has been noted that having a nurse leader in

> the role is in accordance with the idea that nurses, of all the health professionals, are multiskilled and are the most likely group to both plan creatively and to mobilise their forces to achieve real outcomes associated with improved patient or client care. (Stewart, Usher, Nadakuitavuki & Tollefson, 2006, p. 48)

Effective leadership is obviously only successful if leaders have sufficient numbers of followers with the requisite skills to carry out the necessary work. The World Health Organization (2005) has identified that the loss of skilled health professionals from developing countries through migration is a key challenge in terms of being able to develop and sustain robust health care systems.

Nursing migration

For Fiji, nursing conditions are inclusive of the number of experienced nurses available to do the work and in developing countries, nurses do not necessarily leave their current jobs to take up new ones at home. The problem of nurse migration out of countries like Fiji is a major challenge in terms of the continuing provision of quality health care in the country. Aiken et al. (2004) explored patterns of nurse migration, focusing on developed countries, including Australia and New Zealand, that are currently involved in the active recruitment of nurses from developing countries. They found that nurses leave developing countries for reasons such as lower wages, poor working conditions and poorly funded health care systems. However, factors that encouraged nurses to migrate were not only higher salaries, perceived better lifestyle and education opportunities. Rather, it was the active recruitment by affluent countries that was found to be an important element in the continued depletion of a necessary skilled workforce from countries like Fiji. While Fiji's nurses and those of other developing countries do contribute remittance to the home country (Brown & Connell, 2006), amounts paid decline over time. Thus, the advantages of contributing foreign capital are outweighed by the disadvantages associated with the loss of a country's skilled health professionals. Thomas (2006) contends that "migration is a symptom of the deteriorating health systems in many poor countries" (p.278), but she also discusses the recruitment strategies that developed countries use to entice nurses away from home. Of significance was her finding, in a study of Indian nurses, that reasons nurses gave for leaving home were not purely economic. Rather, "a large

number of respondents indicated strong feelings of neglect" (p.280) by society and the government as a reason for migration. This finding is significant for Ministries of Health, where the possibility of paying increased attention to nurses' concerns may contribute to mitigation against migration out. Participants in Thomas's study identified that "pessimism…regarding the possibility of fulfilling the ideals of their profession is one of the factors responsible for international migration" (p.280).

Ross, Polsky and Sochalski (2005) found in their study of nurse migration into the United Kingdom that "of all the countries losing more than one percent of their nursing stock to the UK in 2002, only New Zealand is a high income country" (p.257). There is increasing evidence that developing countries are losing a skilled nursing workforce to rich countries. This is of great concern to the affected countries and was the subject of discussion at a meeting of Ministers of Health in Samoa in 2005. At this meeting, it was noted that:

> International migration has grown in volume and is now an important social issue in many parts of the world, as trained human capital moves largely from less developed nations to most developed and affluent ones, with adverse implications for health services and economic development in the source countries. (World Health Organization, 2005b, Migration of Health Personnel, Meeting of Ministers of Health for the Pacific Island Countries, Apia, Samoa, 14-17 March, 2005)

A World Health Organization study completed in 2002 concluded that "up to 15% of doctors and nurses in most Pacific Island countries and areas had migrated over the past years and there were indications that the trend was likely to continue for some time in the future" (World Health Organization, 2005b). Clearly, while affluent countries struggle with concerns over recruitment and retention of nurses in particular hospitals or health centres, the problem for poor countries has another devastating dimension.

Women and leadership in Fiji

A discussion about women and leadership in Fiji must take into account both traditional and contemporary notions of leadership within the country and also customary and more recent ideas about the role of women as leaders within this context. Nayacakalou (1975) developed a useful and definitive account of traditional and more recent – to the 1960s - leadership in Fiji, making a distinction between rural

and urban settings. Unfortunately, for the purposes of this review, 'leadership' in Nayacakalou's account is almost exclusively about men leading in Fiji, whether this be in a village or an urban organization. Although obviously a man of his time (his studies were undertaken in the 1950s and early 1960s), it is disappointing to see little more than a vague reference to female descendants of male chiefs as having the title of 'Adi' or 'Bulou', in contrast to the title 'Ratu' which is given to men of rank. Apart from this, no reference is made to women in leadership positions in Fiji. Nevertheless, the account is extremely useful in providing an understanding of the evolution of leadership in the country, which provides some basis for an understanding of how nursing leadership has evolved and operates today. As Nayacakalou (1975, p. 2) notes: "it is necessary, in a study of the higher levels of leadership, to take into account the bases from which they are built". The account clearly identifies the significance of status in relation to who is able to formally lead in Fiji, but being able to successfully perform in the role is also seen to be crucial to maintaining a leadership role. Another important point made is that any leadership decisions made must be seen as having "the customary legitimacy" (Nayacakalou, 1975, p. 35), that is, while other people – termed 'outsiders' - may influence a decision made by a leader, the decision must appear to have been actually made by the person in the formal leadership position.

In contrast to Nayacakalou's (1975) account of internal Fiji leadership structures, Rokotuivana (1973) discussed the need for strong Fiji leadership and decision-making in response to the efforts of developed countries such as Australia to influence Fiji's economy and social structure more than three decades ago. Her account is not dissimilar to Sharpham's (2000) writings about the negative effect of colonisation on Fiji leadership earlier last century, and serves as a timely lesson for current partnership arrangements between the Fiji Government and international aid agencies. For Rokotuivana (1973), a major problem of the early 1970s was in allowing foreign influences – she called them 'businessmen' – to direct the course of development in Fiji, that is, to lead Fiji in a direction that was decided by outsiders. She warned the leaders of Fiji of the time about what she described as a tendency for newly independent countries (Fiji gained independence from Britain in 1970) to be "…catapulted into development by modernizing leaders who pay little attention to criticizing the goals of the development process" (Rokotuivana, 1973, p.13). Her

major concern was that, as members of a former colony, the people of Fiji, and most importantly their leaders, had a heritage of 'over-respecting' the former colonizers, with the inherent danger of failing to adequately critically question some of their development imperatives. Noticeably, Rokotuivana was exhorting Fiji's leaders to meet their leadership obligations, rather than allowing somebody else to function as the major decision-makers for the country's direction. While making no mention of leadership and gender in her discussion, it is crucial to note her involvement in such affairs as a woman of Fiji in the early 1970s.

While comprehensive written accounts of women and leadership in Fiji are not prolific, Tuivaga (1988) provides a beneficial explanation of the role and status of women in Fiji, which gives some insight into who among the indigenous women of Fiji would most likely be in a leadership role. Social rank associated with 'chiefly' familial connections is identified as the key indicator of a woman's status and her role in Fiji society, and only a woman of rank is traditionally accorded deferential treatment by other society members. This raises concerns for Tuivaga, who suggests that as women become more highly educated, they will begin to challenge their place in a male-dominated society and insist on having more influence at the highest decision-making levels. It is a little unclear about whether Tuivaga is referring to women of high rank who are also highly educated, or whether she believes that women in Fiji, regardless of their social rank, will take on more of a leadership role with the benefit of increased education opportunities and achievement. Jalaal (2002) stands out by proposing that women have *the* major role in the rebuilding of Fiji following the coup of 2000. She notes that women are instrumental in the process of building peace internationally, and that their skills should be much better utilised in Fiji to achieve good governance in that country. Logically, similar claims might be made about women who are nurses being instrumental in improving health care in the country through key leadership roles. Leckie's (2000) study into gender issues and the nursing culture in Fiji is significant here; she found that nurses generally confronted multiple impediments to becoming more powerful within the health care sector, citing the influence of Florence Nightingale as well as Christianity as contributing to their lack of power.

Nursing leadership in Fiji

There are currently approximately 1,750 nurses in Fiji (Usher & Lindsay, 2003/2004). The majority of these nurses are women. While not ignoring the importance of the role of men in nursing in Fiji, the focus of this discussion will be on the women, because of the disproportionate numbers of women in the profession. Unfortunately, there is little published literature about nursing leadership, or indeed nursing, in Fiji. As has been discussed, leadership in the country is largely confined to historical chapters of autobiographies or histories of the country, where the role of traditional chiefs is thoroughly explored. An exception to this is McLaughlin's (1944) opinion-based article about the Fiji School of Nursing and this is mostly concerned with the provision of modified nurse education programmes to 'native' (sic) peoples. Nursing is developing a literature, though the majority of information is still to be found in government reports and unpublished manuscripts (Driu Fong, August, 2003; Stewart, January, 2004; Usher, November, 2003). Nevertheless, the significance of nursing influence on health care is beginning to gain some attention. Usher and Lindsay (2003/2004) note the importance of the contribution of nurses to delivering sustainable and cost effective health care throughout the country. Some of the nurses involved in their study of nurse practitioners expressed a strong opinion that they wanted increased decision-making power in their roles. Obviously, nurses want to participate in terms of leadership of health care in the country. It may be, however, as Laverack (2003) found in his attempts to empower Fiji villages, that the chief, who is invariably a man, remains the ultimate decision-maker in rural communities. Laverack notes that despite the fact that a person who is not a chief may have proven him or herself to be extremely capable, ultimately he or she must defer to the chief in any matters concerning culture or tradition. Nevertheless, Stewart, Usher, Nadakuitavuki and Tollefson (2006), writing about nursing leadership education in Fiji, contend that such leadership development will contribute to the capability of health industry leaders which will in turn equate to a better health system

While much has been written about Fiji's history, particularly concerning relatively recent political upheavals (Robertson & Tamanisau, 1988; Sharpman, 2000) and accounts of foreigners travelling in the country, there is a gap in the literature concerning published accounts of how health care is managed and the contribution of nursing leadership to improving health care outcomes. Connell (2007) has explored

the impact of local media upon beliefs and values of people generally in Fiji and Nilan, Cavu, Tagicakiverata and Hazelman (2006) include nursing in their study about career ambitions for school students, but such studies, while useful, tend not to be concerned directly with health care. There were no studies found which used a critical approach to explore nursing leadership and its impact on providing better health care. Also, as will be discussed, nurse leaders in Fiji tend to be middle-aged or older. Although the ageing nursing workforce has become the topic of an emerging literature (Buchan, 1999; Lavoie-Tremblay, Pallas, Viens, Brabant & Gelinas, 2006), no studies were found concerning beliefs about younger nurse leaders. Thus, the current study will make a significant contribution to these gaps and will have wider implications for health care management and nursing leadership throughout the Pacific region.

Postcolonialism and decolonizing research

Origins and application

This review would be incomplete without reference to postcolonialism and the challenges inherent in research with indigenous peoples. Jack and Westwood (2006) support critical ethnography as a useful methodology for international research, but warn researchers about the possibilities of all research reinforcing colonial oppression. As Tuhiwai Smith (1999, p.1) argues:

> From the vantage point of the colonized, a position from which I write, and choose to privilege, the term 'research' is inextricably linked to European imperialism and colonialism. The word itself, 'research', is probably one of the dirtiest words in the indigenous world's vocabulary.

At issue here is the privileged position occupied by the West concerning research involving those that Said (1978) called the Other. Based on Said's seminal work *Orientalism*, Jack and Westwood make a case that "the political distortions and moral condemnations that characterize Orientalism have often been articulated around the notion of 'progress'" (2006, p.490). This whole notion of the Other being defined and explained by the West and compared unfavourably with Western notions of superior progress, is a crucial area for reflection in this study of nurse leaders in Fiji. Studies such as this are engaged in a politics of representation (Jack & Westwood, 2006), where the danger of researcher representing the voice of participants from a 'superior' Western position remained part of my reflection throughout the entire research

process. Concerning this study then, the introduction of the clinical governance framework in Fiji was suggestive of 'progress' in health care activities, and

> the discourse on 'progress' that informed the colonial project suggested that: some 'races' were inferior to others; colonizing powers had a moral obligation to assume control and help develop lesser peoples; the knowledge systems of such people were inferior; only the 'developed' and educated people of the colonizing world were capable of producing valid knowledge; these 'less developed' people…should not be allowed to speak for themselves, until judged 'progressed'. (Jack & Westwood, 2006, p.490)

The intention of postcolonialism is to move beyond hegemonic thinking and practice such as this and Mohammed (2006) exhorts nurse researchers to apply postcolonial theory in all health-related research. This is despite Aboriginal activist Bobbi Sykes' question at a post-colonial academic conference: "What? Post-colonialism? Have they left?" (cited in Tuhiwai Smith, 1999, p. 24). Knowing that critical ethnography allows "…for the relationship of liberation and history" (Kincheloe & McLaren, 2003, p. 465), it remains necessary to continue to guard against not allowing the Other to speak for him/herself.

It is crucial to note once again that postcolonial literature emanated from the work of Edward Said and, as Kennedy (2003) notes, Said's *Orientalism* (1978) remains "the foundational text for post-colonial theory" (p.12). Central to postcolonial theory is this notion of Othering which is concerned with the separation or setting apart of groups of people as somehow different or exotic (Kirkham & Anderson, 2001). Indeed,

> Othering is an act of representation by which identity is assigned, human existence is categorized, people are characterized according to certain criteria…and experiences are homogenized. The roots of Othering lie in imperial exploitation and the colonial project. (Kirkham & Anderson, 2001, p.6)

Extending beyond Said's orientalism, other leading writers and postcolonial theorists, including Memmi, Fanon, Bhabha, Young and Ashcroft, clearly articulate a postcolonial experience that is far from singular and as McClintock (1994, cited in Kirkham & Anderson, 2001, p.6) has observed "third-world countries do not share a single common past or a single common condition called the postcolonial or postcoloniality". Frantz Fanon's major contribution was to propose a psychopathology associated with colonialism. Although Young (2001) notes that the

"orthodox eurocentric Marxist left in Europe has always tended to marginalize the issue of colonialism" (p.276), Bhabha (1994, p. 171) manages to bend Jurgen Habermas to his purposes, borrowing Habermasian theory, for example, as a means of explaining the psychopathologies associated with the colonial project and noting the complexity of the historical contingencies which are brought to bare upon them. Postcolonialism, then, begins from the premise that the colonial project produced profound suffering and alienation throughout the world and demands that those in the West, as Young (2003) exhorts, give knowledge and perspectives not from the West the same significance as those of the West. In this sense modernity has been "fundamentally about conquest [and it is] a discourse which enabled the large-scale regulation of human identity both within Europe and its colonies" (Ashcroft, 2001, p.28). Having said this, colonized societies are in the process (albeit not without a fight) of at times transforming themselves by taking dominant discourses, changing them and using them for their own ends and for their own empowerment (Ashcroft, 2001, p.1), as will be shown in this particular study.

The process of hybridisation remains central to debates around postcolonial theory. Hybridity essentially refers to the notion that no culture can be presented as 'pure' and separate but rather that culture remains fluid, partial and negotiable (Bhabha, 1990, cited in Kirkham & Anderson, 2002). This is of particular interest when one considers the work of Brison (2003), whose study of Fijian rural women included the finding that they are "subjected to the contradictory pressures to be autonomous and to submerge one's self in the community" (p.337). She found tensions for participants occurred around traditional and Western notions of being part of community as opposed to being an autonomous individual. This is consistent with issues around Indian reformist movements, where both Chatterjee (1993, cited in Young, 2003) and Spivak (1987) make reference to the different experiences of rural/urban or upper class/lower class women concerning conditions for women in postcolonial environments.

The literature concerning critical management studies also proved significant for the postcolonial environment within which this study took place. Critical management studies are in part concerned with the 'allowed' discourse within organisations and are about overcoming oppressive influences which impact upon such discourse (Alvesson

& Deetz, 2000; Alvesson & Skoldberg, 2000; Alvesson & Willmott, 1992; Forester, 1993). In addition, and of particular relevance to this study involving Fiji nursing leaders, Westwood (2006) warns that international leadership and management research

> might, based upon a limited, Western-constructed, empirical study, provide an account of a particular leadership style of, say, Indonesian managers. This is abstracted and reified to become and 'Indonesian' leadership style as though all Indonesians behaved in this manner. In the process all variance and diversity are erased, as are any self-representations the other may want to mount. (p.97).

Nevertheless, it is also of note, as Memmi (1974), describing his own situation in the 1950s, points out: "I discovered that all colonized people have much in common, I was led to the conclusion that all the oppressed are alike in some ways" (p.5).

It will become increasingly apparent during a reading of this thesis that the issues around postcolonialism and critical management research partly informed analysis, findings, discussion and recommendations within this study.

Chapter Summary

The major issues considered within this review of the literature, which contextualises the question of how the clinical governance framework contributes to the changing role of the nurse leaders in Fiji, includes the fact that clinical governance is a response to adverse patient outcomes internationally. In addition, the key role of effective leadership in relation to clinical governance and therefore improved patient outcomes has been outlined in this chapter. The elements of effective nursing leadership are similar to those of any leadership effectiveness, being those of the transformational leader, but nurse leaders have particular challenges associated with the oppressive structure of health care organizations. Effective nursing leadership has been closely associated with the empowerment of nurses, and nursing empowerment closely linked to improvements in patient outcomes and increased patient safety. In Fiji, the women who are the nurse leaders are confronted with the same forces as nurses internationally, but special issues around colonization and postcolonialism, and the place of women in Fiji society, bring another dimension to their efforts to be effective as nurse leaders.

Conclusion

In conclusion, the review of this literature has provided a context within which clinical governance is introduced into health care systems. In addition, literature which clarifies the situation for nurse leaders in Fiji has been highlighted. The review has provided a critique of existing literature concerning nursing and Fiji, and has revealed a significant gap concerning the situation for nurse leaders as health reform, including clinical governance occurs in the island nation. It should be noted that literature from this review and other literature that further informs this study including key critical management literature, will be included in the following chapters. This includes the next chapter which explains the methodology and interpretive framework for this study and later chapters concerning analysis, findings, discussion and recommendations.

Chapter 3: Interpretive framework, methodology and method

He spoke of very simple things – that it is right
for a gull to fly, that freedom is the very nature
of his [or her] being, that whatever stands against that freedom
must be set aside, be it ritual or superstition
or limitation in any form.
(Bach, 1970, p.83)

Introduction

This chapter will explain the interpretive framework, methodology and method chosen to explore the implications concerning introducing a clinical governance framework on the changing role of nurse leaders in Fiji. Habermas's theory of communicative action has been chosen as the interpretive framework for this study, because his sociological analysis of the ways in which communication occurs allows for an interpretation of the Fiji nurse leaders' response to their changing roles. This is in situations where social, historical, political and cultural factors continue to strongly influence the ways in which they act and are acted upon. As Forester (1999, p. 47) argues:

> when we examine it, ordinary action turns out to be extraordinarily rich. What passes for 'ordinary work' in professional-bureaucratic settings is a thickly-layered texture of political struggles concerning power and authority, cultural negotiations over identities, and social constructions of the 'problems' at hand.

Forester's reference to social constructionism in this sense means that we *construct* knowledge rather than merely discovering it, and that we do so unavoidably from an historical, cultural and social perspective (Schwandt, 2003). Therefore, bureaucratic 'problems' and processes, as will be seen, are largely constructed by actors in a particular setting.

From a methodological perspective, Carspecken's (1996) five recommended stages for critical qualitative research provided a framework within which to conduct, analyse, and partly provide an explanation for the findings of this research. His overall approach, with its fundamental links to Habermasian ideas about communication and power, has been linked to research outcomes which can result "in a transformative praxis that leads to the alleviation of suffering and the overcoming of

oppression" (Kincheloe & McLaren, 2003, p.472). The methodology, as Carspecken suggests, has been used as a guide only and I worked 'to articulate my own intuitions' (Carspecken, personal communication, July 20 2005), rather than be constrained by a particular framework during the research process. Nevertheless, the reader will see that as a guide, the methodology assists the critical researcher to articulate historical, cultural, social and certainly for Fiji, political influences that participants were telling me shaped their world. The research methods will also be described in detail, with clear links to the use of Carspecken methodology in this study.

Interpretive framework – Habermas's theory of communicative action

The lens through which analysis was undertaken in this study consisted of Habermas's theory of communicative action, with his vision for a world where ideal agents have the ability to communicate on a 'level playing field'. Outhwaite (1994) cites those who ask how the "…notions of emancipatory knowledge and practice, of ideal communication situations and of communicative action and discourse ethics cope with the grubby reality of self-interested conduct, self-serving institutions and political horse-trading" (p.137). How indeed? This chapter discusses how such a theory is not necessarily an 'impossible dream', and explains how Habermas's work provides allowance for 'horse-trading' in contemporary society.

Habermas is a critical theorist and created his theory of communicative action to answer the question: 'how is social order possible?' His contention is that "in modern, secular societies social order rests chiefly on the basis of communicative action (action coordinated by validity claims) and discourse, which together help and maintain social integrity – that is they provide the glue that keeps society together" (Finlayson, 2005, p. 47). His theory has two parts that support each other. One is about the difference between communicative action and other (less desirable) sorts of action, and the other concerns his discussion of 'lifeworld' and 'system', which house the different sorts of action in which social beings engage. The theory of communicative action aims for a world where people (actors) communicate with each other both verbally and non-verbally in an attempt to reach a mutual agreement about themselves and their actions in the world. The theory encompasses a number of key components. Habermas appreciates that such an 'ideal speech situation' does not

occur in the world for a number of reasons. The first of these concerns the three 'worlds' that each individual inhabits. The 'objective' world is the world of physical things (e.g. the orange chair is in the room); the 'subjective' world is the world of the individual's inner experiences (e.g. I don't like the colour of the chair). Other people only have privileged access to an individual's subjective world – that is; we only tell or reveal some of our inner world to others. The third world that we all inhabit is the 'social world of norms and roles' (e.g. you shouldn't judge the colour of other people's chairs).

The lifeworld

The second and related central component of Habermas's theory is concerned with his notion of the 'lifeworld', wherein people lead their everyday lives, relating to each other, making decisions and taking actions. The lifeworld embodies elements of 'cultural reproduction', where life is lived based partly upon continuing with usual traditions, 'social integration', where life is lived through solidarity within the social group and a sense of a stable group identity, and 'socialization', where life is lived consistent with a sense of one's own identity as being harmonious within a larger collective group and with the knowledge that generalized ways of thinking and behaving are transmitted between individuals and groups (Outhwaite, 1994). The major problem for Habermas is that this 'lifeworld' is being overtaken by "the market and administrative processes characteristic of the modern world" (Outhwaite, 1994), referred to as 'systems'. Consistent with this, he makes a distinction between the lifeworld and 'systems' and proposes that societies need to be considered simultaneously as comprising systems and lifeworlds.

Habermas (1984) contends that systems develop out of the lifeworld and that they do so through controlling or 'steering' media such as money and power. He calls this the 'colonization' of the lifeworld by systems. Simplistically, the link between the colonization of the lifeworld and the absence of an ideal speech situation can be seen as the distinction between the 'language of the lifeworld', which is an authentic communicative use of language to achieve mutual goals, and the 'language of systems', which is "strategic or success-oriented speech, parasitic on the former, which simulates a communicative orientation in order to achieve an ulterior purpose" (Outhwaite, 1994, pp. 45-46). It is important to note that "it is not that the lifeworld is

a source of 'good' communication in a sea of 'bad' instrumental action…but that the lifeworld is the terrain in which these conflicts are fought out" (Ray, 1993, p.34). The way in which nurse leaders in Fiji have responded to the introduction of a quality improvement framework, which is largely 'borrowed' from the United Kingdom, provides a worthy illustration of Habermasian ideas about lifeworld and system. What has been the meaning, for a developing country, of the adoption of a Western system for managing health care services?

Communicative action

The objective of a critical social theory such as this is "…to achieve emancipation from systematically distorted communication" (Scambler, 1987, p. 168), that is, to identify the problems in modern society, 'lay them out' as it were, so they can be solved through the ideas of communicative action. 'Communicative action' is one of the four types of action which Habermas distinguishes as being about the ways in which we function within the three worlds – the objective world, the subjective world, and the world of roles and norms. The other types of action are: goal-oriented or 'teleological' action, which is about making decisions based upon the rational notion of doing certain things to achieve certain ends (goals). So-called 'strategic action' is the variant of teleological action, where the person (actor) also considers the possible behaviour of other actors who are making decisions and taking action to achieve *their* own goals. A third type of action is 'normatively-regulated action', where members of a group in society align their decision-making and behaviours towards common values and expectations of behaviour which have been agreed to by group members. The fourth type, 'dramaturgical action', is consistent with the self presenting as one of many 'actors' in a real-life drama (Outhwaite, 1994).

At an elementary level one can begin to see that where action is not 'communicative' (i.e. it is either teleological/strategic, or normatively-regulated, or dramaturgical) it has been adjusted by individuals in ways that render it problematic in terms of achieving an ideal speech situation. For Habermas, these alternative forms of action are consistent with a society where the lifeworld has been colonized, and the intention of his critical social theory of communicative action is the universal emancipation of society "…in which individuals actively control their own lives, through an enhanced understanding of their material and psychological circumstances" (Scambler, 1987,

p.166). This is notwithstanding Holmes's (1992, p. 947) view that dramaturgical action is less about adopting a façade for use in the world and more about dramaturgy as a means of emancipation, emphasizing "…the tragedy, gravity and splendour of human life, the unity and continuity of the Self, the importance of genuineness and the pursuit of the realization of the best potentials of self and others".

This notion of 'genuineness' becomes important when one considers Habermas's point that in *achieving* communicative action, four claims must be considered. He calls these 'validity claims' and the requirement is that "…what is stated is true, comprehensive, spoken in sincerity by the speaker and that the speaker has a right to be engaging in the speech act" (Street, 1992, p. 93). These constitute the criteria within which differing claims about 'reality' can be considered and compared against an ideal speech situation. I have commented upon the possible meaning of adopting the clinical governance framework for Fiji. From a Habermasian perspective, one method by which this could be understood in this study involved taking entries from my reflexive journal about various meetings I attended during fieldwork. It was then possible to consider the validity claims made by various 'actors' in those meetings. Forester (1992, p. 49) notes that "…when we speak…we typically make four practical claims on listeners simultaneously": we claim an external state of affairs that others may or may not believe to be true; we appeal to norms that others may view as legitimate or which they may challenge; we provide access to our subjective states, such as joy or disappointment, that others may or may not view as sincere; and we choose the language we use, which others may allow or which they may confront as being beyond their understanding (Forester, 1992, p.49). The key here, as Knorr-Cetina (1981, cited in Forester, 1992, p.47) points out, is to "…appreciate even the most apparently simple 'bureaucratic' interactions as entry points, as windows through which we might look to see the extraordinary political complexity of professional and organizational work".

The themes in this situation are also consistent with Habermas's concession of giving a bit of "…ground to functionalism in that he accepts that some degree of systemic steering is necessary in order to manage the complexity of modern lifeworlds" (Ray, 1993, p.48). That is, some degree of 'horse-trading' is going to be happening. Nevertheless, he also identifies that such 'colonization' "…requires new forms of

democratic participation aimed at curbing economic and administrative power". Clearly, it is only through such discourse that freedom from the oppressive forces of the steering media is possible. One of Habermas's crucial interests concerned the ability of communities to achieve such freedom, to become emancipated, and "…emancipation in a Habermasian sense refers to decolonization of the lifeworld" (Ray, 1993, p. viii). In studying organizational life, as will be seen, emancipation in this sense can refer to a change in the discourse within an organization, when aspects of 'colonization' are altered to enable a more equitable situation for actors.

Habermasian theory - origins

An understanding of Habermas's projects and their usefulness in the world is easier if one identifies where they came from and possibly how and why he formulated his ideas. For example, noting his work concerning the 'public sphere' assists us to appreciate that it is possible that such free and open dialogue might well occur in the modern world. Fay (1987) notes Habermas's argument that it is *because* people use speech to communicate with each other that there is an *implied* ideal of being able to arrive at a collective autonomy in speech and action. In his early work, Habermas's exploration of such collective autonomy could be partly explained in terms of his study of the 'public sphere', that is the "emergence of a reasoning public out of the literary public of the salons, clubs and coffee houses of 18-th century Europe" (Finlayson, 2005, p. 10). In this situation, private citizens (albeit only a small group of men – most women and poor, uneducated people were not part of these conversations) held reasoned discussions about the world and freely arrived at ideas about conditions that were for the general good of a society. Although this ideal declined as newspapers and so on achieved large circulation and were eventually taken over by capitalist corporations (i.e. became part of the system rather than the lifeworld), the fact that they existed at all seems to have informed Habermas's opinion that such an 'ideal speech situation' could again be possible in the world. Habermas's theory of communicative action allows the researcher to interpret events in the world through a lens which recognizes the simultaneous existence of lifeworld and system. For this study, the nurse leaders in Fiji who were the participants, and myself as the researcher, experienced a situation which included the imposition of a foreign system into the lifeworld of Fiji. This was about the introduction of the clinical governance framework, which had been imported from the United Kingdom and was being

adapted for use in Fiji, against a background of health delivery over decades which had included a combination of traditional medicine combined with Western medicine (Katz, 1999).

In this study, everyday activities and conversations about the management of health services in Fiji provided rich detail about power relations and about the possibilities for fruitful social change in this environment. Consistent with Forester's (1992) view, what happened in Fiji was an excellent illustration of people attempting to resolve bureaucratic problems often through the use of power and authority. In a practical sense, and undertaking Habermasian fieldwork, I was free to *not* presume an ideal speech situation, to recognize that political 'horse-trading' *was* going to occur, and that such recognition would allow the participants and I to eventually reveal the tangible communicative practices which were shaping relationships (Forester, 1992) in this setting.

Habermasian theory - applied

To illustrate, Hyde and Roche-Reid (2004, p. 2619) applied Habermas's theory to a health care setting, arguing that "…the lifeworld of childbirth is colonized by the technocratic system" of obstetric medicine. They describe a form of 'horse-trading' that goes on between midwives and obstetricians, aimed at securing access to pregnant and labouring women, noting the influence or otherwise that midwives felt they had over obstetricians. They further suggest that it is the midwives who valiantly hold the 'lifeworld' sacrosanct, while the obstetricians are concerned with money and power. This is consistent with Habermas's notion of system colonizing lifeworld, but I would argue and indeed found in my research, that nurses and doctors do not belong in the respective camps of lifeworld and system, but instead are all engaged to varying degrees in perpetuating less than ideal conditions (speech actions) during the course of their work in a health care setting. The key was for us to expose this together so that we could begin a discussion about positive social change.

In addition, Forester's (1992, p. 51) brief account of a City Council staff meeting provides an example of how actors in a bureaucratic setting will inevitably act "…politically and ethically, assigning responsibility, reproducing hierarchy, and conferring and attaching legitimacy". The Fiji Ministry of Health was no different in

this respect. Nurses, doctors, managers and other personnel participated in a stream of interaction which would have been familiar to any health worker in Australia. With all the apparent good intentions in the world, in all situations "dominant ideological practices and discourses [are going to] shape our vision of reality" (Kincheloe & McLaren, 2003, p. 440) and we are going to reproduce them. Again, and not forgetting the possible conceit that it is claimed can go together with efforts at emancipation (Kincheloe & McLaren, 2003), we worked together to emancipate ourselves, at times, *from* ourselves. If "critical research is research for the people" (Fontana, 2004, p.99), then this was research for the nurse leaders, for me and ultimately for the people of Fiji.

The Frankfurt School

It is important to note that Habermas's thinking was very much shaped by his teachers, and by his work at the Frankfurt School (Outhwaite, 1994). Although he came to challenge Horkheimer and Adorno, especially their notion of *aporia* (from the Greek, meaning 'no passage' or 'perplexity'), he shares many of their ideas about contemporary society. As critical theorists, all three subscribe to the view that instrumental rationality as a dominant form of knowledge has had a negative effect on the social world. Privileging technological and natural scientific knowledge above other forms of knowledge carries with it the danger of human life and interaction being reduced to a 'means-ends' kind of process, where all that matters is achieving outcomes with the greatest efficiency. A good example of this in the current health care environment is an economic rationalist approach with a focus on financial management at the expense of the provision of optimum health care (Davies, 2005). Adorno and Horkheimer were extremely disillusioned by such a world, and arrived at the rather depressing conclusion that as human beings became more 'rational' (even their social theory being an example of such 'rationality'), there was nowhere to go (there was *aporia*), as ever-increasing rationality would lead to more means-ends actions and more rationality and so on (Finlayson, 2005). This process of Enlightenment was seen to imprison human beings, who would only become more miserable and subject to increasing levels of poverty and would become more violent with and intolerant of each other as rationality continued.

Habermas was dissatisfied with such conclusions, believing that Adorno and Hoekheimer's analysis was flawed and that, in fact, there existed another more hopeful explanation for the human condition and for what was possible. He remained supportive of some original ideas from the Frankfurt School theorists in that he took a multidisciplinary approach to his work. Indeed, his theory of communicative action draws upon, extends and complements the work of such theorists as Weber, Durkheim, Parsons and Lukacs, as well as Adorno and Horkheimer (Finlayson, 2005). Habermas's approach was not to denounce the work of other theorists, but to use such understandings to develop and extend an understanding of the modern social world. Also, he was obviously extremely interested in the notion of instrumental rationality and the concern with problems of domination and oppression in the world. However, he was much more positive than his teachers about the possibility of emancipation, not just for individuals, but also for society through the development of more democratic institutions. As a researcher, a major attraction for me in the work of Habermas is his interest in American pragmatism, and the view that "philosophical theories and concepts have to pay their way by making a difference to the lives and experiences of real people in the actual world" (Finlayson, 2005, p. 18). While critics of Habermas may argue that his theories do not 'pay their way', neglecting as they do, for example, oppressed peoples in developing countries, I would argue that they form the basis for the sort of critical pragmatism referred to by Forester (1993). In this way, the theory of communicative action informs research into organizations in ways that reveal distorted communication and thereby provide a platform for positive change. That is, as will be shown in this study, the researcher can apply the theory as a vehicle for facilitating the emancipation of oppressed peoples.

As a critical researcher I attest to the view that

> Critical research can be best understood in the context of empowerment of individuals. Inquiry that aspires to the name of *critical* must be connected to an attempt to confront the injustice of a particular society or sphere within the society. (Kincheloe & McLaren, 1994, p. 140)

Emancipation remains the basis for Habermas's work. However, he provides a useful idea about why people behave the way that they often do in contemporary society. He moves away from the notion of a mass of 'stupid' consumers who are behaving irrationally because they do not know any better. Instead, he notes that people are,

many times, "…funnelled by economic and administrative systems into certain patterns of instrumentally rational behaviour" (Finlayson, 2005, p. 24). For a critical researcher, this is an important attitude towards other people. As Kincheloe and McLaren (2003) point out: "…as critical enquirers who search for those forces that insidiously shape who we are, we respect those who reach different conclusions in their personal journeys" (p. 437).

Critical theory

I have referred thus far to Habermas as the key theorist who informs the interpretive framework for this project. In doing so, some reference has been made to first generation Frankfurt School critical theorists such as Adorno and Horkheimer. An understanding of critical theory and its place within this research would not be complete without reference to other fine thinkers and theorists who take the 'critical' approach. Plato's *Parable of the Cave* provides a platform from which one may begin to consider just what it is that critical theory is concerned with:

> Down in the bowels of a cave, chained in such a way that they can only see the shadows of objects projected onto the wall in front of them, ordinary humans live in a world of illusion which, in their ignorance, they take to be real. Their collective existence is structured on this mistaken belief so that they organize themselves around pointless, misconceived activities. However, one of them escapes from the cave, sees the falseness of his or her life, and eventually comes to look directly at the sun which is the source of all light. (Fay, 1987, pp. 10-11)

Consider for a moment the falseness of the world of the cave compared to contemporary society. Reflect upon those institutions that *seem* to serve the needs and interests of everyone, and which we generally may believe do serve all of our interests (we are in the cave), but in fact exist principally to support the welfare of a powerful minority. The role of critical theory is to assist us to be the person who escapes from the cave and who comes to realise that institutions and conditions that may have appeared to us to be in our interests, and to be natural and unalterable, can be, in fact, the opposite. When gazing 'directly at the sun' in this way, we have an opportunity to participate in necessary societal changes so that *everyone* can escape from the cave. This means critical theory research can enable us, living as we do in varying degrees of ignorance about the world, to understand it better and to then go about improving it.

Although critical tradition can be found as far back as Plato, and as Fontana (2004, p.94) suggests, "examples of critical thought have always existed", Karl Marx is credited with being the profound influence on critical theory as it evolved through the time of the Frankfurt School/The Institute for Social Research, founded in Germany in 1924 (Slater, 1977) to the present day. Indeed, Habermas's work and the Frankfurt School's critical tradition continue to inform and provide a basis for much critical research being undertaken by nurses today (Fontana, 2004; Hardcastle, 2004; Williams, 2005). Although not classic Marxism, with its distortion of Marxian critique, the work of Habermas, his colleagues and many contemporary nurse researchers continue a long critical tradition, aimed at creating a society in which justice prevails through a process of praxis. Freire's (1999, p.28) definition of praxis as "reflection and action upon the world in order to transform it" illustrates effectively the goal of critical nursing research, including this study. In addition, nursing research internationally continues to promote a critical perspective to research concerning both nursing education and nursing practice (for example see Crowe, 1998; Huntington & Gilmour, 2001; Manias & Street, 2000).

Kincheloe and McLaren (2003) claim that "*critical theory* is a term that is often evoked and frequently misunderstood" (p.433). They note that it generally refers to the work of the scholars of the Frankfurt School, which originated some 70 years ago. Neo-Marxist writers and scholars such as Adorno, Horkheimer and Marcuse studied the dynamic nature of capitalism at the time, the domination and oppression that accompanied such change and the notion that "injustice and subjugation shape the lived world" (p. 434). As mentioned, their students, such as Habermas, continued this conversation, further developing their ideas and challenging many of them. Noticeably, Brazilian criticalist and political activist Paulo Freire also shares some of Habermas's views about a possible 'ideal speech situation' when he writes about the problems of power and domination, and proposes a "…communitarian alternative [where] power is relational, characterized by mutuality…Power from this perspective is reciprocity between two subjects, a relationship not of domination, but of intimacy and vulnerability" (Christians, 2003, p. 233).

As this research will be conducted within a theoretical framework of critical social science, Comstock's (1982, p.370) notion of undertaking a research activity which is

"…appropriate to a social science of *praxis*" has been vigorously pursued. Creswell (2003) discusses advocacy/participatory approaches, stating that "the research should contain an action agenda for reform that may change the lives of the participants, the institutions in which individuals work or live, and the researcher's life" (pp. 9-10). This research clearly has an 'action' agenda, whereby there is an intention by the researcher to participate in activities that attempt to enable both researcher and participants to see the situation in a wider socio-historical context. Comstock (1982, p. 388) provides a useful framework within which to consider such research:

i. Identify social groups or movements whose interests are progressive.
ii. Develop an interpretive understanding of the intersubjective meanings, values, and motives held by all groups in the setting.
iii. Study the historical development of the social conditions and the current social structures that constrain action and shape understandings.
iv. Construct models of relations between social conditions and the current social structures that constrain actions and shape understandings.
v. Elucidate the fundamental contradictions which are developing as a result of actions based on ideologically frozen understandings: compare conditions with understandings; critique the ideology; discover possibilities for action.
vi. Participate in a program of education with the subjects that gives them new ways of seeing the situation.
vii. Participate in a theoretically-grounded program of action which will change social conditions and will also engender new, less alienated, understandings and needs. (Return to Step 2).

This notion of *praxis* is central to critical theory. As Grundy (1987, p. 105) notes: "the constitutive elements of praxis are action and reflection". She cites Freire's views that praxis occurs in reality rather than as an abstract concept and that people have the opportunity to think about the reality of their social world, to recognize that it is socially *constructed* and, knowing this, have the ability to *reconstruct* it. A useful way to think about praxis is to consider that it is

> not action which maintains the situation as it presently is; it is action which changes both the world and our understanding of that world…In this way praxis is informed by an emancipatory interest which would preserve for all groups the freedom to act within their own social

> situations in ways which enable the participants to be in control of that situation, rather than the ultimate control of their actions residing elsewhere. (Grundy, 1987, p. 113)

Praxis is consistent with Gramsci's (cited in Kincheloe & McLaren, 2003, p. 447) conclusion that "…the starting point…for any higher understanding of self involves consciousness of oneself as a product of power driven social forces". Only then is it possible to criticize 'things as they are' and to go about changing them, then to criticize them again and to continue to make changes as needed in the current social world. In this instance I was concerned with a 'praxis of leadership', where

> praxis…stands for the ability of all persons to engage in acts of leadership which help in the transformation to a way of life which incorporates participative principles; leadership, in this regard, is both a critical and a shared leadership. (Foster, 1986, p.18)

A discussion about critical theory today also requires a positioning of critical theory in the early 21st Century. Kincheloe and McLaren (2003) provide a challenging discussion about what they term a 'reconceptualized' critical theory. While remaining true to the basic tenets of critical theory (it is concerned with misuse of power in the social world; it is concerned with emancipation; it is concerned with self-reflection and taking individual and community action to achieve social change) they support Habermas's notion of the relationship between people and 'system' by stating that "a reconceptualized critical research endorses a much more subtle, ambiguous, and situationally specific form of domination that refuses the propaganda assumption that people are passive, easily manipulated victims" (p. 440). This study was undertaken within this particular contemporary notion of critical research.

Critical ethnography

Consistent with the decision to employ Habermas's theory of communicative action as a lens through which to view the situation for this study, critical ethnography was chosen as the most appropriate methodology within which to conduct the research. Historically, ethnography has been described as "a social scientific description of a people and the cultural basis of their peoplehood" (Peacock, 1986, cited in Vidich & Lyman, 2003, p.60). This somewhat limited view is further expanded and explained in terms of the understanding that:

> ethnographers are not mere passive or neutral recorders of behaviour occurring independently of them; rather, this behaviour is deeply affected by the process of each looking at each other looking at each other. (Fay, 1996, p.45)

To further extrapolate, Thomas (1993, p.4) states: "conventional ethnography asks what is; critical ethnography asks what could be". Whilst it is acknowledged that other ways of conducting the study could have been employed, I was very much aware of the cultural issues surrounding the questions for which I wanted to find answers. With this study, I wanted to go beyond describing the social experience of the people involved. Description is extremely useful in enlarging our understanding about what is going on in a particular situation. This study, however, focused on exploration of the culture of health care in Fiji, the culture of nursing leadership, the cultural aspects of introducing a clinical governance framework in this country and the wider political, historical, social and economic factors that influence what is happening. Also, issues of inequality, power and oppression were explored and such knowledge provided a platform for the major focus of this critical ethnography which was attempting to use knowledge for social change (Thomas, 1993, p.4). The point needs to be made that critical ethnography emphasizes not only cultural typifications, but more importantly "…communicative experiences and structures" (Kincheloe & McLaren, 2003, p. 467). The fundamental aim then, of a critical ethnography such as is this, is emancipation and not merely description.

Linking methodology and method

The critical qualitative framework defined by Carspecken was used as methodology for this study. It has been claimed that 'method' and 'methodology' are often referred to interchangeably when discussing qualitative research (Fontana, 2004), but this should be clarified in the critical tradition. While method can be described as the 'how to' in terms of data collection, methodology is the manner in which phenomena are approached and interpreted and which defines critical studies (Fontana, 2004; Harvey, 1990; Morrow, 1994). In this discussion about methodology, I will be identifying the techniques by which data was collected, but this should not lead the reader away from the overarching philosophical approach that informs Carspecken's methodology and my conceptual approach in this study. Carspecken's methodology, with its primary link to Habermasian ideas about communication and power, will now be described comprehensively. It is crucial to note Carspecken's own views that the

methodology should be used as a guide only and that the researcher should 'work to articulate their own intuitions' (Carspecken, personal communication, July 20 2005). The methodology is termed 'critical ethnography' in his impressive book *Critical Ethnography in Educational Research* (1996), however, as Hardcastle, Usher and Holmes (2006) point out "he prefers the term critical qualitative research (CQR) over critical ethnography" (p.151). Such thinking is linked to his idea that the methodology could be the basis for any social research (Smyth & Holmes, 2005) and the reader should be able to see the usefulness of the methodology for a range of qualitative research studies.

Ethical considerations

Ethical approval for this study was gained both from the James Cook University Human Ethics Committee and from the Fiji Ministry of Health's Chief Executive Officer (CEO). At the time of commencement of the study, the process for gaining ethical approval occurred through the CEO, rather than an ethics committee within the Ministry (See Appendix A). Access to participants was granted via the Fiji Ministry of Health's Director of Nursing/Director of Health System Standards, and as Creswell (2003) notes, ethical issues need to be anticipated and planned for throughout the research process. This included during the development of the research problem statement, in the purpose statement and research questions, during data collection, analysis and interpretation, and in writing and disseminating the research.

The James Cook University and National Health and Medical Research Council (NHMRC) ethical criteria were adhered to throughout the study, with informed consent gained from all participants. Cultural considerations were of particular relevance in this study in Fiji. As Laverack and Brown (2003) note, the context of cross-cultural research comes with particular responsibilities; they highlight the need for "western researchers to have a prior understanding of the fluid social dynamics and complex balance of relationships that occur between research participants in a cross-cultural setting" (p. 341). To this end, an information sheet and sample/theme questions were initially forwarded to the Director of Nursing/Director of Health System Standards for review and she agreed that they were culturally appropriate. As has been stated, permission to conduct the research was gained from the CEO, following direction from the Director of Nursing/Director of Health System Standards

that this was the appropriate avenue through which to seek approval for the project. Cultural sensitivity involved the recognition that I was 'not local' and therefore needed 'academic knowledge' (Meleis & Lipson, 2004) through extensive reading about the socio-political and economic history of Fiji and the history of the health care system, nursing and nursing leadership. Such knowledge was supported by 'experiential knowledge' insofar as I had previously spent extended periods of time in Fiji with the Fiji nurses and nurse leaders, discussing each others' personal lived experiences as nurses and nursing leaders. Thus there was no 'laundry list' or 'cookbook' approach to optimising cultural sensitivity and neither should there have been. Rather, as Campinha-Bacote (1998, cited in Meleis & Lipson, 2004) so clearly implies, cultural competence is more of a journey than a state to be achieved and my journey was one of consistent reflection around the issue of remaining culturally sensitive within the environment of the Fiji Ministry of Health.

The participants

Choosing the participants for semi-structured interviews involved a process of initially identifying all of those nurse leaders who were in the most senior nursing positions in Fiji. These were people who worked in the Head Office of the Fiji Ministry of Health, or were the Nursing Managers (the most senior nurse) in hospitals or community health services in Fiji. In this way participants were targeted (Merkens, 2004) to fulfil the aims of the study, but account was also taken of representing different points of view. As Morgan (1988, cited in Merkens, 2004, p.167) suggests:

> in organizations not all of those interviewed should come from the same level in the hierarchy or belong to single department, if the culture of an organization is being investigated.

The Fiji Ministry of Health is not a large organization. Fiji has approximately 1,750 nurses (Usher & Lindsay, 2003) with a relatively small number of senior nurse leaders. I approached twelve of these and six of the prospective participants agreed to be interviewed. Access to the participants was negotiated through the Director of Nursing/Director of Health System Standards at the Fiji Ministry of Health. Recruitment of participants occurred initially through letters sent via the Director of Nursing/Director of Health System Standards. Participants were invited to respond via e-mail, fax or telephone in the first instance. Subsequent respondents were contacted through individual letters accompanied by consent forms and information sheets

which outlined the project, the interview process and all participant welfare particulars (Appendices B & C). The information sheet included details about the purpose of the research and of the interview; the right to withdraw from the interview at any time, or to not answer particular questions during the interview process without reason or penalty; the right to temporarily suspend the interview if they so wished without reason or penalty; the right to subsequently have the interview excluded from the research at any stage and the audiotape and transcript of the interview destroyed without reason or penalty. Participants were asked again about their understanding of the research project before they were asked to sign the consent form and to verbally agree once again to participate in the interview. Interviews were conducted with respect to the privacy of each participant, in their offices or in private conference rooms throughout the Fiji Islands, in order to maximise their feeling at ease with the interview process, including the use of audiotape.

A crucial point concerning the participants' agreement to being interviewed, in terms of the need for them not to feel coerced, was the traditional hierarchical structure within the Fiji Ministry of Health. While the Director of Nursing/Director of Health System Standards was the 'gatekeeper' concerning access to prospective participants, it was made very clear that there was no obligation to be interviewed. The fact that six of the prospective interviewees declined to participate, while six agreed to do so reinforced the success of my efforts to ensure *voluntary* participation.

Brief demographic information about the six nurse leaders who agreed to participate in the interview process is provided (Table 3.1). They all had major management and leadership responsibilities and were able to influence policy and nursing and health care practice to differing degrees. All had various roles within the Ministry of Health during their nursing careers. All had completed their basic nursing qualification at the Fiji School of Nursing. All had qualifications beyond a basic nursing qualification. All but one participant had one or more tertiary qualifications. Personally, all but one participant were married with children and grandchildren.

Table 3.1 The participants

Pseudonym	Age	Years of nursing	Nursing experience
Alice	57	30+	• Community • Acute Hospital • Education • Management
Bronwyn	59	30+	• Acute Hospital • Education • Management
Coral	40	15+	• Community • Acute Hospital • Management
Dorothy	59	30+	• Community • Acute Hospital • Management
Edwina	57	25+	• Acute Hospital • Management
Philomena	51	25+	• Community • Acute Hospital • Education • Management

There was also the recognition that this qualitative study involved only a *few* of the nurse leaders who were given much of the responsibility for facilitating this monumental change to health services. As in most qualitative studies, the sample size for this project was relatively small (Minichello, Aroni, Timewell & Alexander, 1990). Due to detailed analysis of the texts in qualitative research, accompanied by prolonged observation at the site, this small number of participants nevertheless provided rich detail about what was happening for nurse leaders as the clinical governance framework was introduced.

Confidentiality was of particular relevance in this study, as the Fiji Ministry of Health is a relatively small community, with the possibility present that particular comments or quotes could be attributed to an individual. In light of this, I have obviously given the participants pseudonyms and deliberately did not choose Fijian first names. This was not out of a lack of respect for local names, but to further distance the participants from the possibility of a breach of privacy. In addition, as a copy of this thesis will be presented to the Fiji Ministry of Health, I have not specifically identified the role that each of the participants had, for example Matron of a hospital, which might well immediately personally identify many of them and be inconsistent with the ethical

requirements for confidentiality in this study. Rather, I have described them all as being in senior nursing leadership positions in Fiji. In addition, interviews were conducted in a private space and as I otherwise spent time working in Fiji as a consultant, conversations with the nursing leaders were an integral component of that consultancy role.

Carspecken's five stages

Carspecken's (1996) five recommended stages for critical qualitative research provide a framework within which to conduct, analyse and provide an explanation of the findings of the research. These are:

- Compiling the primary record (comprising both thick description and more general field notes);
- Preliminary reconstructive analysis (incorporating meaning fields and pragmatic horizon analysis);
- Dialogical data generation (through semi-structured interviews and facilitated focus groups with participants);
- Describing systems relations and;
- Systems relations as an explanation of findings.

Carspecken notes that his critical methodology is drawn very heavily from the work of Jurgen Habermas, and Habermasian ideas about validity. He explains Habermas's theory of ontological categories and identifies these as features of human communication which are universal. While Carspecken notes that he has modified the categories slightly for the purposes of his discussion, the reader will see that his description of objective, subjective and normative-evaluative categories are consistent with Habermas's notions of the three 'worlds' that each individual inhabits – the objective world, the subjective world, and the social world of norms and roles. A sound understanding of these stages is necessary to inform this research and they will now be discussed fully. It should be noted that Stages 1, 2 and 3 of this framework are designed to take cultural structures and themes and to reconstruct them through the use of critical analytic models (Georgiou & Carspecken, 2002; Hardcastle et al., 2006). In contrast, Stages 4 and 5 "discover how routine social actions form and reproduce systems relations that coordinate activities across various reaches of space and time" (Georgiou & Carspecken, 2002, p.690).

Stage 1: Compiling the primary record

This stage involved spending time in the field in Fiji, speaking with and working with nurse leaders both in the Fiji Ministry of Health and in the various hospitals and health centres where they spend much of their working lives. It was necessary also to interact with other managers, nurses and doctors who work with these nurse leaders and to participate in various 'lifeworld' activities in the Fiji Islands, including attendance at church services, given the strong Christian affiliation of many of the participants (Leckie, 2000, p. 191). Simultaneously, the methodology requires the researcher to begin the process of developing broad research questions. In this sense Carspecken is somewhat prescriptive, in that there is a requirement to develop two lists, one comprising the initial questions and one being about the actions the researcher might need to take in order to answer them (Smyth & Holmes, 2005).

Initial questions or issues for this study were:

- What is it like to be a senior nursing leader in Fiji?
- What does leadership mean for the nurse leaders – what do they see as the core components of leadership?
- How does nursing leadership differ from other places, and how is it similar in Fiji?
- How does it feel to be a senior nursing leader in Fiji?
- What qualities do nursing leaders look for in the people coming after them as nursing leaders in Fiji?
- How are nursing leaders mentored in their leadership roles?
- What do nursing leaders think about the strategies for improving health services that are being introduced in Fiji?
- What do nursing leaders know about and think about the introduction of the clinical governance framework in Fiji?
- What do nursing leaders think the impact of the clinical governance framework will be in Fiji?
- How do the nursing leaders see nursing positioned in Fiji in respect to the hierarchy of the multidisciplinary team?
- What is it like for the nursing leaders to be leading and managing so much change in nursing in Fiji?

To answer these questions, I initially identified that time in the field was crucial, as previously noted, and that I would need access to hospitals and health centres to observe the daily challenges and struggles of caring for the health needs of the community in this developing country. In addition, it was necessary to have access to:

- the Chief Executive Officer of the Ministry of Health
- the Director of Nursing for Fiji,
- literature concerning Fiji (both general historical literature and literature about health care and nursing)
- relevant documents which affected health care delivery, such as Strategic Plans and business plans
- media reports and other reports which explained what was going on.

It is also essential in these preliminary stages to identify the researcher's own value orientations. Carspecken (1996) notes that this should occur before the researcher goes anywhere near the field and serves to expose biases so that they can be managed. Bias is fundamental to any qualitative research and the critical researcher is compelled to "…enter into an investigation with their assumptions on the table, so no one is confused concerning the…baggage they bring with them to the research site" (Kincheloe & McLaren, 1994, p.140). As I will explain in this chapter, my own experiences as a nurse leader had informed both my ways of managing and my choice of this topic for my study, that is, my own *baggage*. In addition, there was the opportunity to adapt Carspecken's (1996) idea about

> …having a peer or supervisor interview you on the things you expect to find *before* you enter the field [as this] greatly helps to raise awareness of your own biases and check for them while compiling your field notes and formulating your research questions. (p. 41)

My supervisor and I met and discussed the situation in Fiji from the perspective of both having spent time working with the Fiji Ministry of Health. This was invaluable in terms of assisting me to articulate my own views about the situation in Fiji. This is consistent with the notion that, indeed, researchers *must* come to "recognize where they are located in the normative and identity claims of others and at the same time be honest about their own subjective referenced claims" (Kinchloe & McLaren, 2003, p. 466).

Therefore, to summarise, Stage 1 involves passive observation in the field (Smyth & Holmes, 2005), but, for me, Stages 1, 2 and 3, as will be explained, tended to occur simultaneously, as I found myself involved in adapting the methodology to fit the situation where I was travelling to Fiji for short periods of time to undertake the study. Nevertheless, the principles involved in Stage 1 were applied and for me, involved observing and interacting with staff and clients/patients of the Ministry and subsequently writing volumes of notes in my reflective journal, collecting various reports about the activities of the Ministry of Health, and becoming quite adept at removing items from the local newspapers and carrying bundles of newspaper cuttings home to Australia for immediate and later reference.

Stage 2: Preliminary reconstructive analysis

Stage 2 of the methodology, according to Carspecken, is about beginning to reconstruct meanings from observations that were made in Stage 1 (Carspecken, 1996; Smyth & Holmes, 2005). Reconstructing meaning involves in-depth consideration of the context in which the study is occurring, and to consider Carspecken's use of terms such as 'meaning fields', 'pragmatic horizons', 'horizon analysis' and 'background horizons', which Smyth and Holmes (2005) note could be construed as somewhat remarkable "since it extends the methodology toward phenomenology and hermeneutics" (p.69). For Carspecken, however, such terms are used as being consistent with Habermas's adaptation of these terms as part of critical theory. Reconstructive analysis in the Carspeckian sense presupposes that "every time we act, in every instance of our behaviour, we presuppose some normative or universal relation to truth" (Kincheloe & McLaren, 2003, p.466). As will be seen, this presupposition guides every stage of analysis. It should be noted that while this stage is referred to as 'preliminary', strategies employed for analysis here continue throughout the study. In this study, interview texts formed a major component of the data, so that developing initial meaning fields and undertaking pragmatic horizon analysis proved a vital tool for interview text analysis.

Meaning fields

Meaning fields are no more and no less than an attempt by the researcher to glean possible meanings from what they are seeing, hearing or experiencing. This is always going to be tentative, as the researcher constantly strives to appreciate their

own preconceptions when trying to understand meaning. As I became more familiar with the life of Fiji and what it meant to be a nurse leader in Fiji through spending more time there, it became increasingly (although cautiously) possible to gain an 'insider's' view about what was going on. This is about "trying to understand meaning the way your participants do" (Carspecken, personal communication, June 2005). The aim here is concerned with attempting to take the position of the person speaking and the person listening (first and second person positions). Only then is it possible to take a third person position, that of 'observer', in order to build or produce a 'model' to explain the findings. When a person takes action they will always do so, as Willis (1977) found, to maintain a dignified sense of themselves. So meaning fields will always have boundaries; there will always be some point that an actor is making, while simultaneously struggling to reinforce a positive identity.

Again, as in the Willis (1977) study, if this good sense of self is threatened in some way, if the need for a positive identity cannot be met possibly because of dominating forces, then people will find another way to do this, which can sometimes be through the use of oppositional activity. So *identity* claims are vital in reconstructive analysis and are those that happen when somebody acts; because doing or saying something is making a claim that this is the appropriate and legitimate thing to do or say in a given situation. In the Carspeckian methodology then, reconstructive analysis involves searching for evidence of interactive power in field notes (and in my case interview texts). If misuse of power results in subordination and if subordination results in oppositional activity, then examples of this will provide a clearer picture about what is happening. It is vital to understand these key constructs in the methodology when creating meaning fields and subsequently to undertake pragmatic horizon analysis of selected sections of text.

The pragmatic horizon

This notion of a pragmatic horizon "comes from regarding action, rather than perception, to be most primary in experience" (Carspecken, 1996, p.103) and is important because in analysing the identity of individuals we have a significant source for understanding the cultural systems they inhabit (Carspecken & Cordeiro, 1995). This horizon obviously comprises, in the Habermasian sense, elements of lifeworld and system, and actors are engaging in either communicative action, or in

another type of action (either teleological, or strategic, or normatively regulated, or dramaturgical) when making their claims. Actors make their claims against the social, cultural and political background of their world. The claims of these actors must then be foregrounded against the horizon which surrounds them and/or which they bring forth. The components of the pragmatic horizon can be explained by initially taking an example of a claim that a nurse leader might make in a hypothetical situation. If one could imagine for a moment that a nurse leader makes the statement: 'I am a visionary person' or perhaps 'I consider myself to be tough but fair'. What possible meaning could we take from such assertions? These comments should be considered in light of Carspecken and Cordeiro's (1995, p. 88) statement that:

> actors work daily to construct and maintain a sense of self, deserving the positive regard of others. They must draw upon available cultural themes and intersubjective understandings to produce these constructions. These cultural themes, in turn, often reflect the economic, legal-political and physical-environmental location of those who employ them in their identity constructions.

In the foreground are the statements 'I am a visionary person' and/or 'I consider myself to be tough but fair'. It is necessary to reconstruct the meaning of these statements by engaging in comprehensive consideration of the context in which a possible study involving this person is occurring, and to consider Carspecken's use of terms such as 'meaning fields', 'pragmatic horizons', 'horizon analysis' and 'background horizon'. Analysis of the statements would initially involve considering what possible meaning the speaker or other people in the setting might infer from the statements and as Carspecken notes, "meanings are always experienced as possibilities within a field of other possibilities" (p.96). Meaning reconstructions are preliminary and often wrong, but they lead to more detailed horizon analysis.

When reconstructing meaning with pragmatic horizon analysis, Carspecken directs the researcher to be increasingly precise, and identifies "…five main categories of reference and claim within the horizon of meaningful acts" (p.104). These categories should be considered in terms of the notion that each actor making a statement, or a claim, as has been explained, is always engaged in reinforcing a positive social identity. Firstly, the nurse leader in the hypothetical sample statements is making an identity claim. He or she is saying 'it is good to be a visionary leader and it is good to

be tough and fair. I am a clever, or competent, or decent person saying these things. They are good things for a leader to be.' This is a claim that the leader has a certain identity. Secondly, the nursing leader is making a claim that their statements are intelligible to the people he or she is addressing. In this sense, they are assuming that there are shared linguistic symbols for terms like 'visionary' and 'tough' and 'fair' and that these intersubjective symbols would be understood by others in that setting. Thirdly, the leader is making a claim to social legitimacy. In this sense, they are saying that the role they have adopted, that of the visionary, tough, fair leader, is a socially appropriate way for a leader to be in this setting. The fourth category is a normative claim, and in that sense the leader is saying that 'leaders in our situation should be visionary, tough, fair people'. Finally, there is reference to the leader's subjective state; he or she may be inferring that they are a serious and conscientious person. Again, subjective states constitute identity claims: 'this is who I am – a visionary, tough, fair, serious and conscientious person'.

This type of analysis is extremely important in providing some clue about what is viewed as socially acceptable in this situation and what is going to be accepted and reproduced by others. If the leader had said 'I'm a myopic, weak and unfair person' (as unlikely as this might ever be), then that would give quite a different impression of the cultural milieu from which this leader emerges. Identity claims are not always explicit and foregrounded as in this hypothetical example. A nurse leader will probably *not* say 'I am weak and unfair'; rather his her or identity claim will most frequently be implicit, because identity claims inhabit all meaningful acts.

As can be seen, pragmatic horizons are extremely complex and their structures do not necessarily determine all action. Rather, a structure is "drawn upon, reproduced or altered by actors. Paradigmatic structures are fundamentally claims, some of which gain stability and some of which fail to catch on when other people refuse to affirm them" (Carspecken, 1996, p. 108). In the example given, if 'being tough' fails to catch on in this setting, then the leader may well feel obliged to change their statement and indeed behaviour in order to maintain a positive social identity within a group. Also, one can begin to see how dominant forces may alter apparently 'visionary' leaders or indeed followers in an organization dominated by short-term thinking and behaviour. Further, this type of analysis is much more revealing in terms of

leadership studies than asking simple questions such as 'what is leadership?' Alvessen and Skoldberg (2000) exhort researchers to ask questions such as 'if we think of leaders as visionary people, what does that cause us to see, or think or talk about?' If we say 'our leaders are restricted in their vision' what then do we discuss? In the critical sense such discussion moves one away from "the unreflective reproduction of traditional cultural values" (Habermas, 1984, cited in Alvesson & Deetz, 2000, p. 90) and toward the examination of all statements or behaviours that emanate from actors based upon the collective validity criteria of "comprehensibility, sincerity, truthfulness and legitimacy" (Alvesson & Deetz, p.91). If one conceives of health care systems (of which nursing is obviously integral) as possibly being traditionally hierarchical and somewhat oppressive, then Carspecken's methodology and his use of the pragmatic horizon enables the recognition of where dominant forms of communication are problematic.

The methodology also of necessity involves the researcher protecting "herself from the accusation of simply projecting her own beliefs onto other people" (Carspecken, 1996, p.140). This occurs through a number of procedures which include Stage 3 techniques, but also involves checking reconstructions with the participants ('member checks'), using peer debriefing, having prolonged engagement with participants and using 'strip' and 'negative case' analysis. Once frequently occurring cultural themes have emerged from the analysis, strip analysis involves taking a 'strip' from the primary record (in my case, these was interview text material from the dialogical data) and checking that this is consistent with the cultural theme. I employed strip analysis, as will be seen and a variation of negative case analysis, to see whether observational data 'matched' the interview texts and whether my analytic themes were strong.

Stage 3: Dialogical Data Generation

Hardcastle et al. (2006) suggest that Stage 3 of the model varies from Stages 1 and 2 in that dialogical data generation serves to assist the researcher to gain the insider's position in relation to the culture. For me, conducting semi-structured interviews with Fiji's nurse leaders provided moments of intense understanding and surprise as they spoke of matters which had previously gone unsaid in our everyday interactions. This is consistent with an idea that people "will often talk during interviews in ways

they seldom talk in everyday life" (Carspecken, 1996). He claims that this may be because

> …very often people are not listened to as intently as the researcher listens to them, taken as seriously as the researcher takes them, and supported in the exploration of their feelings and life as much as a skilled researcher will support them. (p.154)

Certainly, as will be seen, one participant's assertion that she 'was not going wait another fifteen years to get promoted to Sister' was a revelation in a culture where the predominant theme was one of age and seniority being revered and unquestioned. This was consistent with Leckie's (2000, p.178) view that in contemporary Fiji society "even the most progressive women eventually confront 'old realities', not just from the past but as daily realities in the present". My role during this stage proved to be just as Carspecken has suggested, in that we seemed to construct an environment that was conducive to participants being able to safely explore possibly controversial issues during the interview process. The interviews were all organised in private rooms away from the activities of the Ministry of Health and this created an environment where the nurse leaders were able to share information about their lives and work that was able to profoundly inform the research process.

Stage 3 of this study occurred over a twelve month period, with three of the interviews being conducted initially, and three a year later. This was in part for logistical reasons, as I arranged periods of time in Fiji, and as the nurse leaders were able to secure time away from their busy working lives to participate in the interview process.

As researcher, it was crucial that I also remained cognizant of my own preconceptions in the situation. For the participants, and for me as the researcher, the situation always occurs where "when we narrate something, even in telling our own story, it is…the voice of our culture – its many voices, in fact, that is heard in what we say" (Crotty, 1998, p. 64). I was constantly reminded that I was participating in the research process and that as a critical researcher, I would be learning and changing along with the participants (Carspecken, 1996; Hardcastle et al., 2006; Street, 1992).

Stages 4 and 5: Discovering system relations; Using system relations to explain findings

The key to the final 2 stages is to take the information that has been collected and analysed in the first 3 stages and to link it to 'broader sociopolitical aspects' (Hardcastle et al., 2006) of what is going on in the situation being studied. For example, the site for this study is multifaceted, in that the nurse leaders function in various hospitals, or health centres, or the central office of the Ministry of Health. The social system surrounding the site, however, influences the decisions they make and the activities they engage in during the course of their work. In addition, international movements in health care, including the situation for nurse leaders and the introduction of clinical governance in Western countries, provides for a broader 'system' within which to consider the situation in Fiji. The task of the researcher in stages 4 and 5 is to step back once again from the situation being studied and review relevant literature that helps to explain the findings, specifically "macrolevel social theories" (Smyth & Holmes, 2005, p.72). As has been noted, the goal is to determine "why people act the same over and over again…, as class structures, gender relations, and asymmetric relations…are all produced by people but often escape peoples' awareness" (Hardcastle et al., 2006). My experiences with stages 4 and 5, as will be shown, reflects the cyclical stages of Carspecken's methodology and I used portions of the stages as they are explained. Stages 4 and 5 are based upon Willis's (1977) cultural reproduction theory. Carspecken's (1996) model of 'social structure' provides a framework within which to analyse social systems. The idea is that:

- society is a complex set of intersecting factors;
- there is therefore no reified 'social system'; rather, society consists of systems relations – "varying degrees of interaction between social groups and social systems" (p. 186);
- the conditions of social action, be they cultural (internal), or political or economic (external), influences what actors do;
- actors do reproduce systems relations of their own volition, but they do so influenced by these social conditions.

Considering social conditions, or 'conditions of action', assists the researcher to study systems relations by paying attention to the different sites associated with a study. In Fiji, as will be shown, health care is delivered across many different sites and the goal for stage 4 is to discover relationships between the sites.

Stage 5, then, consists of explaining these relational systems in terms of existing macro-level theories. For this study the goal was to consider the broader political, economic and cultural system of the Fiji Ministry of Health and to link these findings to sociological theory in order to explain what was going on. A crucial issue for this study in Fiji concerned that of Fiji as a country which had been colonized and has only relatively recently achieved independence. Postcolonial theory as well as Habermas's theory of communicative action was therefore important in terms of analysis for this study.

Researcher orientation/philosophical position

Glesne and Peshkin (1992) note that the type of research we undertake and the research methods we choose to use, identify much about our opinions regarding the nature of reality and what we believe fits as valuable knowledge. For this study, I have chosen to undertake a qualitative rather than quantitative study. Further, my approach is clearly constructionist; I am approaching the study from a theoretical perspective of critical theory, specifically Habermas's theory of communicative action; and I am undertaking a critical ethnography utilising Carspecken's critical methodology. My approach reflects my beliefs and assumptions about the world, which are consistent with Comstock's (1982) conviction that "…all men and women are potentially active agents in the construction of their social world and their personal lives; that they can be the subjects rather than the objects of socio-historical processes" (p. 371). The rejection of a quantitative approach for this study is compatible with the idea that positive social science and research methods "…reifies social processes by naturalizing social phenomena, addressing them as eternal to our understandings, and denying their socio-historical constructedness" (Comstock, 1982, p. 371). Similarly, as will be explored in this study, concepts such as 'clinical governance' are reified in ways that make them difficult for people to understand and apply in the real world of health care planning and delivery.

The decision to undertake a critical ethnography, rather than some other type of qualitative approach, also emanates from a conviction that the situation being studied is one where issues of power and control have long influenced social processes and outcomes. Rokotuivana (1973) wrote of concerns about developed countries such as Australia attempting to control the direction for Fiji. More recently, Murray and Storey (2003, p. 219) make reference to the difficulties of post colonialism, mentioning the "…historic and structural relations which have placed Oceania at the periphery of the globalising system since colonial times and have reproduced networks of dominance and subordination within its societies and economies". To undertake an ethnography is to study, write about, think about and talk to other people (Thomas, 1993), which is the manifest aim for this study. To do so from a critical perspective is to make the assumption that the situation in Fiji potentially remains one (as was described by Rokotuivana) where there is a need to use science as "…a method for self-conscious action rather than an ideology for the technocratic domination of a passive populace" (Comstock, 1982, p.372).

Undoubtedly, my role as researcher was affected by such beliefs and assumptions as I began this project, and was equally affected by my beliefs and assumptions about health care and particularly health care management and leadership. Such beliefs were influenced by my own experiences as a participant in both providing health care to patients and clients and in managing and leading in health care organisations. As a nurse and midwife working in hospitals and community settings and as a leader and manager in a tertiary referral hospital, I participated in the use of different forms of power in my interactions with other health professionals and with patients. Particularly in the role of leader and manager, I utilised power and control to achieve organisational goals. This is not withstanding that the goals I was attempting to achieve might have been quite honourable, for example insisting that staff work within their legal scope of practice, or requesting that employees work overtime to complete a surgical case on a needy patient. The issue is: how empowered or participative were the 'other actors' in these and many other situations, or did my use of power sometimes (or all the time) place others in the position of merely being passive actors in the larger system. Was I also a passive actor by following through with the rules of the organisation? Further, as a consultant to the Fiji Ministry of Health, did I inadvertently reinforce aspects of colonialism in my apparently sincere

attempts to share knowledge acquired in Australia in this developing country (Stewart, 2006b)?

For Foster (1986), standard studies of leadership consider the use of domination and authority, group dynamics and differing patterns of influence, and fail to account for "culture, politics and relations of power within both groups and organisations" (p. 3). This study *did* consider such issues during the research process. Reflecting on this particular study, clinical governance activities could be seen as extremely honourable and good activities. Nevertheless, how could they best translate to activities for Fiji, rather than being imposed in a form better suited to a developed country? Without doubt, I had to remain transparent about such beliefs throughout this research activity and my assumptions about what I was learning during the process of the research. Beliefs about health care systems, particularly management and leadership in health care systems, beliefs about the influence that developed countries have on developing countries in terms of developed countries sometimes either inadvertently or quite deliberately attempting to impose values, beliefs and systems on their less powerful neighbours. Creswell (2003) warns that as researchers we make very specific claims about what knowledge is, how we know what knowledge is, what values go into such claims, how we write our research, and our process for studying it. My orientation is in keeping with Carspecken's (1996) statement that we "criticalists find contemporary society to be unfair, unequal, and both subtly and overtly oppressive for many people. We do not like it, and we want to change it" (p. 7). My motivation for this particular study in Fiji concerned my curiosity about what the impact of a framework like clinical governance, with elements espoused to be 'good' for health care, would mean for Fiji. If a focus on customers, management of risk to minimise harm to both customers (patients/clients) and workers, good professional education for workers and optimum management of resources was to be adopted in Fiji, what could this mean for not only nurses and other health professionals, but for the whole community of Fiji. What might happen to either improve conditions for many people, or inadvertently reinforce the oppressive elements of the situation?

The Researcher – position-taking

Consistent with Carspecken's (1996) methodology, the researcher is required to 'position-take' as an integral part of the research process. This entails more than the

notion of having a 'role' as researcher. Indeed, Carspecken notes that, in relation to the participants in a research study, "trying to describe [their] roles with words is risky and will never fully capture what the role is" (p. 136). Logically, similar claims could be made for the researcher role. The position that the researcher takes is closely linked to the experiences of the participants. We come from different places in the world, with different cultural typifications. To 'position-take' in this situation is to be reflective about personal cultural norms I initially employed in the attempt to gain meaning from the participants in relation to their experiences. Then I became a 'virtual participant' by considering participants' experiences from each of their points of view. As Carspecken (1996, p. 99) points out: "the researcher must 'virtually occupy' all the positions of the other actors within the setting in order to be able to infer meaning fields". A 'meaning field' is about attempting to identify what a participant meant by certain behaviour or comment, recognizing that meanings will be experienced "…as possibilities within a field of possibilities" (p. 96).

From my perspective as researcher, in many ways I am an 'outsider' as an Australian national but nevertheless am a nurse and health professional who has spent periods of time working with Fiji health professionals in Fiji. It is possible to consider the literature regarding the researcher's position in the research process, and make some assumptions about what might have happened which could have negatively impacted the research, and to attempt to overcome those potential problems. The notion of reflexivity is a key element of critical research. For me, this meant much more than merely thinking about or writing journal notes about what was happening during the course of the study. Instead, reflexivity in this sense "is an attempt to identify, acknowledge, and do something about the limitations of the research" (Fontana, 2004, p.99), which could, in fact, have been impeding the emancipatory aim of the whole investigation.

de Laine (2000) takes a slightly different view from that of Carspecken in her discussion about researcher roles, acknowledging that the researcher "…has to achieve some workable balance between participation and observation" (p. 109) and claiming there is a necessity to function as an 'insider' when learning about the practices at the site, and then as an 'outsider' who is able to achieve some level of detachment in order to critique those practices. Carspecken (1996) provides some

procedures which could be useful in avoiding the researcher problem of inadvertently projecting my own beliefs and values onto participants and which include the use of 'member checks' – inviting comments from participants about the primary analysis of interviews to see if they agree with the preliminary findings. The real issue for the researcher is that he or she is viewed as not separate from the social scene being studied, but is in fact part of that situation in different ways at different times during the research process. Indeed, it has been acknowledged that such a researcher "…can be located spatially, culturally and within the research process in similar or different places from the participants" (Grbich, 2004, p. 69). Rather than assuming a definite and unchanging 'role' in the research process, as might have occurred with a positivist tradition where the researcher studied, then captured and then understood (Denzin & Lincoln, 2003) from a detached and neutral position, today, to take a position as researcher can be seen somewhat like informed consent, and "…might be more appropriately defined as processual and ever-changing, and subject to negotiation over and over again" (de Laine, 2000, p. 95).

Essentially, then, the researcher is part of the research process and the researcher position must include some degree of reflexivity, regarding their place within the research and how the researcher's worldview might impact upon the study itself. From my point of view, assumptions and beliefs about health care leadership and management and about the relationship between developed and developing countries, which I have discussed, needed to form part of my continuing reflection, including entries in a reflexive diary, throughout the research process. Such reflexive notes then became as integral to the research as the observational or interpretive notes made during the study. As researcher, I must acknowledge my own background, beliefs and values and as Carspecken states, make tacit comparisons between the normative realms that I am familiar with and the normative realms that the participants seems to claim as valid. This must be recognized as fundamental to the research process.

Conclusion

This chapter has explained the interpretative framework, methodology and study methods for this research, explaining the links between Habermas's theory of communicative action and Carspecken's methodology in this critical ethnography. I have provided a brief introduction to the participants and briefly contextualised their

lives as nurse leaders within the wider system of the Fiji Ministry of Health. The following chapters 4, 5 and 6 'Analysis and Findings' present the findings from the prolonged time I spent with the nurse leaders and working with participants and others in the Ministry in Suva and throughout the Fiji Islands.

Table 4.1: Chapters 4, 5, 6 - Themes

Themes	Sub-Themes	Components
Finding our voices: understanding that we are powerful	Being colonized	British colonization Florence Nightingale tradition Being a Christian
	Clinical governance as empowering	Having our voices heard Getting educated as opportunity
	The role of external consultants	Fiji people as decision-makers Culturally appropriate systems
	Doing 'our time'	The wait for education New roles for young leaders
Legitimizing our role as the facilitators of best patient outcomes	Being patient focused	Changing the focus from health professionals to patients Patient safety Benefiting the community Personality/motivation of nurses
	Having the 'heart' for nursing – understanding the nurses	Knowing the nurses/getting closer to the nurses Resources for the nurses The uniform Getting in the nurses' minds
Recognition of our capacity to take a leading role in health care	Learning to be multidisciplinary	Redefining our sense of belonging to the nursing 'group'
		Achieving equity with the doctors
	Being effective leaders	Nursing leadership internationally
	Taking the lead	Effective leadership/being visionary
	Challenges to our capacity	Being a bridge
		Retiring together/Public servants
	Contributing	Migration of our nurses
		Leaving a legacy Telling our grandchildren

Chapter 4, 5, 6 Analysis and Findings

Introduction

We can lift ourselves out of ignorance, we can find
ourselves as creatures of excellence and intelligence and skill
We can be free! We can learn to fly!
(Bach, 1970, p.27)

The nurse leaders of Fiji are members of a social group whose identity has been influenced by being Fijian, by being women (all of the nurses in senior nurse leader positions at the time of this study were women) and by being nurses. As people of Fiji, their experiences of the world are those of being raised and educated in a developing country. Their country was colonized by the British during the time of Empire. As women of Fiji and as women of a colonized country which has only fairly recently achieved independence, they have been subject to the traditionally subservient place of women in Fijian society. The recent political past of Fiji has been unstable, with coups in 1987, 2000, and 2006, which again has impacted upon their personal, social and working lives. As nurses, they have been influenced by traditional healing practices in Fiji, by Western nursing traditions, and by the health system in which they work. In this study, it was important to understand initially how *identity* shaped what was going on and what the impact of yet another 'Western' system, the clinical governance framework, had upon their lives as nurses and beyond. It is crucial to note that "the analysis of identity will often provide an important key to understanding a cultural system" (Carspecken & Cordeiro, 1995, p.88).

The Carspecken methodology also involves the researcher in considering systems relations as a key element of the research process. The Habermasian lens and Carspecken's methodology challenged me "to overcome the troubling disjunction between actor-focused and institution-focused ('micro' and 'macro') research strategies" (Giddens, 1984 cited in Forester, 1993, p. 2) by considering both actors and system in the analysis process. Indeed, Alvesson and Skoldberg (2000, p.136) remind us that "critical research does make particular demands on distance, in order to relate the action level to a broader social, historical and economic context and to avoid being trapped by culturally shared meanings". The task with this study, then, was to explore identity and other issues and to analyse these in relation to the Fiji Ministry of

Health and to the world of the Fiji Islands itself. Only by going beyond actor-focused issues could a real understanding of the situation for the nurse leader in Fiji be comprehensively considered. I have explored, therefore, the 'everyday' experience of the nurse leaders as they describe it, and simultaneously the social, political, historical and economic constraints of the social system that is Fiji. Considering the impact of system highlighted the link between what the nurse leaders were saying and how it was to be a nurse leader in Fiji.

The purpose of this study was to explore the question: 'How does a clinical governance framework contribute to the changing role of nurse leaders in Fiji?' The following three chapters, which go someway towards finding an answer to that question, have a basis in the Carspeckian coding process which was employed and refined to arrive at major themes, sub-themes and key components of sub-themes. Carspeckian methodology was utilized during analysis and while Carspecken borrows some of his interpretive framework from Habermasian notions of the 'worlds' that subjects inhabit, Habermas's theory of communicative action guides this analysis. This is specifically in terms of the notion of lifeworld being colonized by system, and about the possibilities of the 'ideal speech situation' in organizations such as the Fiji Ministry of Health, where communicative action is compared with other, strategic forms of action. Themes, sub-themes and components of sub-themes are presented as Table 4.1 of this thesis.

The three chapters that comprise analysis and findings mirror the three major themes that emerged during analysis. The first is: 'Finding our voices: understanding that we are powerful'. This chapter focuses on the nurse leaders' views about how it is to be a nurse leader in Fiji, including those influences that they believe both inhibited and empowered them in their roles. My interactions with the nurse leaders, during my time spent working in Fiji and during the interviews, included much discussion about the influences of 'the West' in Fiji. The indigenous people of Fiji refer to themselves as *kai viti,* meaning 'people of Fiji', and all foreigners are *'kai valagi',* which can be loosely translated as 'people from far away' or foreigners. I would often hear comments such as 'there are a lot of *kai valagi* around this week', meaning several Australian, New Zealand and other Western consultants were undertaking short visits to Fiji as part of international aid consultancies. The *kai valagi* were often referred to

using humour, the inference being that they were something of a necessary nuisance because the nurse leaders had to take time to meet with them to discuss aid strategies. This was significant as will be shown in this chapter. *Kai valagi* had colonized Fiji, and Western influence continues to pervade Fiji culture, including nursing culture. The first chapter describes what the nurse leaders think and feel about the impact of the (originally Western) clinical governance framework on their professional lives, with a particular focus on effects of colonization, including Florence Nightingale's influence on Fiji nursing, Christianity and nursing culture and the role of current *kai valagi* consultants. The issues of education and of Fiji's respect for elders are also explained, including what this means for Fiji's nurses and their hopes for the future. As both constraining and empowering, all of these influences were viewed by Fiji's nurse leaders as eventually assisting them to reflect on their own emerging power as the clinical governance framework was introduced.

The next chapter, Chapter 5, has the theme 'Legitimizing our role as the facilitators of best patient outcomes'. The focus for this chapter is the participants' view that they are best positioned to make possible a health system in Fiji where the major concern for all health professionals is the delivery of optimum health care to the community. This is inclusive of creating a culture of safety for patients who receive health services either in acute hospitals or in community health centres. During my time in Fiji with the nurse leaders, I was confronted with the same problems related to patient safety as are occurring internationally. The particular issues that are described in this chapter are inclusive of the nurse leaders' perception of difficult working conditions and inadequate financial compensation for nurses, and they linked the nurses' dissatisfaction in this regard with poor patient outcomes. The nurse leaders indicated that their efforts to communicate more effectively with the nurses and to provide better conditions for them would have a direct positive effect on the sort of care that they provided to the patients. Issues of domination are again discussed in this chapter including the symbolism associated with wearing of the nursing uniform in Fiji. Patient safety is also closely associated with the motivation nurses have to be their best, with the nurse leaders' ability to persuade nurses to shift to a culture of patient safety, and their belief that clinical governance was the vehicle that would promote this sort of culture.

In Chapter six the theme 'Recognition of our capacity to take a leading role in health care' provides a focal point within which to describe and discuss the changes that were occurring in the Fiji Ministry of Health, particularly for nurses, which would enable them to take a more equal role with other professionals in leading the health care system. This chapter describes what the nurses think and feel about their growing awareness that they are capable of such leadership. Issues about the move to a more multidisciplinary focus for patient care are described, including the nurse leaders' sense of loss about belonging to a larger group of health professionals rather than only the nursing group. Challenges to their leadership capacity by other professional groups are described, as is their determination to successfully meet such challenges. The chapter describes the participants' desire to be competitive as nurse leaders internationally, including their beliefs about what constitutes effective leadership. Their problems and solutions concerning being Public Servants, nursing migration out of Fiji, and implementing clinical governance successfully are explored. Finally, their conviction that they can take Fiji forward to a better future in health care is identified.

Chapter 4: Finding our voices: understanding that we are powerful

Being colonized

Alvesson (1996, p. 139) makes the comment that the key idea in the Habermasian project is "that people are – or given favorable circumstances may become – the supreme judges of their own best interests". Reading the texts from the interviews provided rich evidence that participants *wanted* increased autonomy in their working lives and to a greater or lesser degree, appreciated the influences of the past and the present on the degree of that autonomy. The key components of the sub-theme were firstly the effects of British colonization, where the 'micro' issue was about following a Florence Nightingale tradition, but the larger 'macro' issues were the overall effect of colonization regarding political, economic and social effects on education; the role of women; and the structure of the health system. As Philomena comments about the nursing hierarchical structure:

> *I believe it's foreign, British, bureaucratic, eh? Most of what we have today is inherited. And maybe that's how we view nursing in Fiji. That nursing has – no, I think it's the bureaucratic, colonial structure in Fiji that is still inherent in our system.*

This reference to British influences was a recurring theme for the participants and it should be noted this was not necessarily in a positive way. The nurse leaders saw the effects of this tradition as continuing for far too long in Fiji and it was viewed as a vehicle for nurses continuing to be passive in the wider context of the health system. Edwina discusses what she sees as the problems for contemporary nursing in Fiji, noting:

> *Our past nurses looked at Florence Nightingale…the past leaders they continued to tell us, be like Florence Nightingale. They don't answer back, you do this, you do that, you are supposed to be behaving in this way…you are supposed to be at the bed…to wait for the doctor to come in.*

The issue here is that while the nurse leaders were describing these influences, the horizontal and vertical dimensions of the pragmatic horizon surrounding these speech acts was extremely enlightening. In the foreground were the comments that colonization was continuing to influence nursing in Fiji. The inference here was that these influences were not desirable. When Edwina mentions Florence Nightingale, it is crucial to remember that she is speaking to me, a Western researcher, whom the participants all claimed had the benefits of being a nurse in a developed country. So we have a probable preunderstanding (Carspecken & Cordeiro, 1995) that Florence

Nightingale is seen as the founder of modern nursing (Street, 1992), but that she comes from a past age. Both Philomena and Edwina are making explicit identity claims in that they seem to be saying: 'we are nurses, but we are not those passive sorts of nurses. We are modern nurses who want to escape from the negative influences of the past'. If I had challenged either participant about being an assertive, contemporary nurse leader (I did not) they would have found it necessary to further explain their position (as in the vertical dimension of analysis) by perhaps referring to normatively-referenced terms like 'old-fashioned' and 'forward-thinking' or subjectively referenced terms such as 'enthusiastic' or 'lethargic' (Carspecken & Cordeiro) in order to defend a sense of this part of their identity.

Philomena and Edwina were accurate in their assessment of nurses in Fiji being seen at times as a generally passive group, but it is not merely the effects of colonization that come into play here. Leckie (2000) writes not only of the 'Nightingale tradition' of nursing; she also note how the "multiple hierarchies of gender, family, politics, colonialism and ethnicity" (p.190) impact upon women in Fiji. In contrast, this group of nurse leaders did not speak as only passive recipients of a hierarchical structure. One participant's exemplar as follows constituted the use of 'strip analysis' (Carspecken, 1996, p. 141) that I employed after the major sub-theme of 'being colonized' was developed. This technique, as has been explained, assisted me to check whether the reconstructed themes were reasonable for this study and that my analytic themes were strong. The participant is speaking about Western influences in her nursing career. Like most of the participants who became nurse leaders, she had spent some period of her career as a Tutor at the Fiji School of Nursing.

> *…in fact locals, locals had run the School…but after that [the] Principal at the School had always been Australian, no New Zealand at that time. And the Australians, in the '80s the Director of Nursing was Australian…I think we had some sort of collaboration with Australia. I was a tutor then…so then when I was called…to go, I said 'this must be, this must be a calling'…I mean the opportunity to be educated was something I had wanted [The Australian Director of Nursing] told me once 'In the event that nursing gets into USP, I want you to do your degree'. That's the thing she told me…So that's the thing, maybe she's seen something in me too, so that's the thing she told me. 'Make sure now,' and we didn't have nursing, ah, we didn't have nursing in there. 'Whenever there's a chance, at USP nursing is going to be here taken at the degree level, you need to do it'. That's OK, that's the thing she told me.*

With all of the interview transcripts, I employed Carspecken's techniques for analysis and also considered his point about the importance of narrative structure (Carspecken, 1996, p. 162) in the analysis. The participant's take on her Western colleagues used a schema of these people as her 'advisors' to a degree but perhaps more as her 'helpers'. My field notes and reflective journal relating to my interactions with her reflected this same schema. I wrote 'She is definitely in charge in our relationship. I am here to help her out but she retains the power over any decisions that are made' (field notes, 2005). Carspecken and Cordeiro (1995, p. 92) note that "comparison of interview material with actual observations of activities will help the researcher determine whether or not there is a good match between talk about identities (produced in interviews) and everyday identity claims". Observed activity in this case closely aligned with the participant's interview material (Carspecken & Cordeiro, 1995, p. 91).

In addition, her indication that Western influences could sometimes be empowering rather than constraining proved to be a consistent theme across all the interviews and during my field observations. The participant's comment that 'locals had run the School' is indicative of a metaphor she used throughout our conversations – she referred to people from Fiji not as 'Fijian' or 'Indo-Fijian' but as 'locals'. When I said 'Fijian' to her on a number of occasions, she corrected me by saying 'local'. I heard this elsewhere from the nursing group, and from other health professionals in Fiji. This contrast between 'local' and 'not local' accounted for describing anyone who was not born in Fiji, and those who were 'not local', in this piece of text, for example, Australians and New Zealanders, were people who could be of assistance in Fiji, but the tacit understanding always was that if one was not local, one should not be making decisions for Fiji. For this nurse leader, the advice about 'getting a degree' from the Australian nurse provided reinforcement of her personal belief that she (and other locals) could use elements of Western culture to further their own careers. Furthering *their* careers was clearly linked to being able to take on roles that non-locals previously had in the hierarchy of the health system. Another participant Philomena's comments about who should lead Fiji nursing are illustrative: 'Being a local person and having a lot of nurses from the same background…therefore leadership in Fiji is probably a bit different because if someone else from elsewhere come and lead in Fiji, they wouldn't have the background'. Philomena has completed

her higher education degrees outside Fiji, but she is adamant that she takes advantage of Western education so that she, as a local, can lead.

Alice and Coral referred to this theme of 'borrowing' from the West by describing their secondary school experiences and how these had contributed to their success as nurse leaders. Alice said

> *..you know my secondary education. I think that helped a lot too. My English for instance. I was able to communicate well both verbally and in writing. At that early stage I was recognized by my supervisors and managers, and I was always involved in little projects and things like that you know.*

Coral is talking about her success in managing personnel in the workplace:

> *So I still think that – that was one of the things that I learned in School…not in nursing school. In secondary school…at that time we had English, heavy English influence at the school…that's where I captured it…I carried that on. I carried that on to Nursing School. And that has developed through the years as I've progressed.*

This can be problematized in that there is the belief that one *needs* English language and influence in order to prosper in Fiji nursing. In the foreground are the participants' overt comments that having English influences has assisted them; in the background are the covert continuing effects of Western domination in Fiji. For these nurse leaders, there is obviously no recourse but to *use* Western influence for themselves and Fiji, given the pervasive nature of such influence. An important reminder here is that

> Hegemony works both through silences and repetition in naturalizing the dominant worldview. There also may exist oppositional ideologies among subordinate or subaltern groups – whether well formed or loosely articulated – that break free of hegemony. In this way hegemony is never total or complete; it is always porous. (Kincheloe & McLaren, 2003, p.471)

The porous nature of hegemony is well illustrated in the nurse leaders' use of hegemonic structures to nevertheless empower themselves. Or as Katz (1999, pp.11-12) explains the advice given to young Indigenous Fijians by traditional elders: "Take what is useful from the European way. Take it and blend it into our own way. But never forget who you are as an Indigenous person". The nurse leaders consistently alluded to 'being Fijian' as a key identity construct, to me as their audience. I remained in no doubt that while I was accepted as a colleague and a researcher, I was *kai valagi* and definitely only a visitor to their country. This was essentially a

normative claim, as individuals would jokingly say (as a subjective claim) 'you are here with us a lot and trying to speak Fijian and we like you so you are *kai viti* not *kai valagi* today'.

Christianity in Fiji

The *kai valagi* also introduced Christianity into Fiji and another key aspect of the participants' identity was that they were Christians. These indigenous Fijian participants' explicit reference to Christianity was indicative of the social situation in Fiji, where the Methodist Church particularly, plays a key role in the governance and social life of the country. Christian influence was both foregrounded and backgrounded during analysis. Dorothy particularly, is speaking of the future of nursing and says of the Nurses Christian Fellowship:

> *We have a lot to offer in terms of our counseling, in terms of our prayers and our bible reading…because of the* ***spiritual*** *aspect of nursing.*

In the background were events that occurred during my time in the field, including the nurses' strike of 2005. In August of that year there was major industrial action that resulted in a strike by nurses of the Ministry of Health. This was an important event in the context of the situation and role of women in contemporary Fiji. Nurses in Fiji have taken industrial action before. Leckie (2000) wrote about a major nurses' strike in 1990, noting that "…some nurses kept their strike participation a secret from their husbands" (p. 190) for fear of reprisal.

In 2005 it was noted that "the country's public healthcare system was in a state of total chaos … as nurses continued with their strike action" (Gurdayal, *Fiji Daily Post*, 6 August 2005). Speaking with nurses during this time, a number of views emerged. One of the nurse leaders strongly disagreed with the nurses taking any industrial action, saying: 'the word "strike" is not in my vocabulary' (field notes 2005). I also recorded that 'G. told me yesterday that the leader of the FNA (Fiji Nurses Association) wanted the senior matrons to go to the FNA building to show their support for the striking nurses, but that the nursing manager from CWM (Colonial War Memorial Hospital) had gathered them together to persuade them not to "leave their posts", so they didn't go' (field notes 2005). A different view was expressed by a nurse leader, who said 'I feel like I'm letting my colleagues down by working here in Head Office rather than being out their supporting them, where I want to be' (field

notes 2005). As has been mentioned, indigenous Fiji has a strongly Christian fundamentalist affiliation and indeed, that "Christian morality is linked with indigenous identity" (Leckie, 2000, p. 191). This seems to be crucial in terms of women's place in Fiji society and for the purposes of this study, the place of nursing in Fiji. Leckie notes that "Christianity has … been central to nursing discourses in Fiji, with the nursing establishment encouraging nurses to seek solace through the Nurses' Christian Fellowship rather than engaging in militant activities" (p. 191). This Christian ideal is possibly linked with the notion that the nurses should remain passive rather than taking strong action to secure better pay and working conditions. Gramsci provides a beneficial insight into possible links between organised religion and issues of power, with the view that

> dominant power in the 20th century is not always exercised simply by physical force but also through social psychological attempts to win peoples' consent to domination through cultural institutions such as the media, the schools, the family, and the *church* [italics added]. (Kincheloe and McLaren, 2003, p. 439)

This theme was important during the time of this study, as was the response of the Government to the 2005 strike, where the nursing union leader was threatened with arrest for leading the industrial action (*Fiji Daily Post*, 6 August 2005).

The 'macro' influences that were crucial to the 'micro' actions of the nurse leaders were available for exploration here, as were the tensions between the two. From a lifeworld perspective, I made record in my reflexive journal about the number of meals I shared with Fiji's nurses during my time there, and my need to remember that the food was always blessed before eating, and all of our lives dedicated to God. As a 'lapsed Catholic', 'saying grace' before meals was something I had long abandoned and I was obliged to reflect upon joining my colleagues in prayer as part of my respectful approach to the people with whom I was interacting during the study. Bronwyn's foregrounded comment about being chosen for leadership: 'I said - this must be, this must be a calling' is representative of a discourse of Christianity that permeated my interactions with the nurse leaders. Although all of the participants did not explicitly mention their Christian beliefs, nevertheless I prayed before eating with each of them, and conversations and indeed Fijian newspapers and television reports were awash with Christian references. This horizon, as can be seen, pervaded the lifeworld of the Indigenous Fijians, as it has since Christian missionaries arrived in

Fiji in the 1830s (Katz, 1999). Such influences from the 19th Century continued through last Century and impact upon Fijian life and culture, including nursing culture to the present day. Obviously, Christianity can be problematized. As Crossley (2005) points out, references to God came, historically, with an absence of the ability to argue with or contest unreasonable societal structures or laws because they were 'God-given'. Theocratic societies such as Fiji exist with a hangover from these "areas of social life once deemed 'beyond argument'" (Crossley, 2005, p.322). So-called 'divine truths', notwithstanding the good intentions of liberation theology, can be as oppressive and destructive as sources of disempowerment as any other 'person imposed' structure or law.

Recent Western influence

So from a Habermasian perspective, the 'lifeworld' of Fiji was colonized by multiple British systems and it can be seen that the influence of these systems persists now, although the nurse leaders struggle at times with what is 'good' and 'bad' about such influences. Although elements of the British lifeworld were obviously imported to Fiji as a component of colonization, it is not unreasonable to equate general definitions of 'colonization' where the West has imported notions of the "privileging of abstract rationality and individual autonomy" (Hanks, 2002, pp.77-78) in similar ways to that of the Enlightenment project, to Habermas's theoretical construct of system colonizing lifeworld. Obviously a distinction must be made between the two, but not completely. Comparisons between sources of the sort of pathologies of modern life such as alienation, loss of meaning, loss of security and identity (Hanks, 2002; Outhwaite, 1994), which stem from system invading lifeworld, bear a remarkable resemblance to possible neuroses associated with Western colonization. As Crossley (2005, p. 38) so clearly points out

> 'Indigenous' cultures are destroyed and with them go both the narrative structures that lend meaning to people's lives and the normative framework they live by. But the economy and the state are incapable of replacing or rebuilding these essential aspects of lifeworld. 'Meaning' and 'morality' cannot be legislated for or bought and sold.

It is also important to make some distinction between a distant past and the more recent past when considering Western influences in Fiji. Bronwyn notes the positive influence of Western mentors in her own life as a nurse leader, saying:

> *[I would ask] just tell me about this. How would you do this? So that sort of thing was ah, that was probably how I found my networking, you know, with people like JCU…you know, anything I want I would just write to them. That adds to, with me, that has probably helped me out.*

The participants were universally adamant, however, that while non-Fijians could be of assistance in helping to shape Fiji's health services, the decision-making belonged to the people of Fiji. This was particularly relevant concerning the role of external advisors and consultants in Fiji – these are people, often Australians and New Zealanders, who work for either the World Health Organization or AusAID or other international aid agencies, and who live in Fiji for differing periods of time offering technical advice on particular projects. During the time of this study, as has been described, the Fiji Ministry of Health was undergoing a major reform process, much of it funded externally, the introduction of the clinical governance framework being a component of this reform. The participants referred to the role of the external advisors and consultants, sometimes explicitly, but more often as background to other foregrounded parts of their narrative.

The participants talked about health reform and what they saw as the impact of clinical governance on health services and on nursing in Fiji. For example, Coral described the changes that are occurring in nursing, and what she says needs to happen for Fiji. Though not directly mentioning external consultants, the inference is that if consultants bring health reform into Fiji, then the reform must be adapted for Fiji culture. She said:

> *We have to look at the Pacific. We have to look at our neighbouring countries, and look at people like Samoa where things are developing very fast, evolving, you know, things like that in nursing. Look at Tonga, and look at the other Melanesian countries. And look at the big first-world countries. Like Australia and New Zealand, our very neighbours. See the nursing trends, see how they have changed to suit the changes that have occurred. And learn from them.* ***But be able to apply the new concept locally. To have the cultural identity of the place where you're from. Rather than importing new ideas, and it all messes up like a stew.***

Making a link between Coral's statement and the notion of the 'ideal speech situation' is necessary here. Forester (1993, p. x) reminds us that "it is the idea of the vulnerable precariousness of our speaking and acting together and not the assumption of the holiness of ideal speech, that animates Habermas's fresh and striking fertile analysis of the practical-rhetorical structure of communicative action". Coral is

inferring not that first-world 'neighbours' should be excluded from Fiji health reform, but that the people of Fiji should have the ability and indeed the option to shape their own future. Further, Bronwyn, who notes the support she has received from people outside Fiji, nevertheless makes a clear case for Fiji controlling its own destiny:

> *A number of overseas groups have come in doing this and that, but where is the, you know,* ***where is the sustainability?****[clinical governance] ah, that's the best. That's the best thing I see happening in Fiji. That area has been, yes, because I'm a clinical, I'm a clinical person, eh.*

Where the nurse leaders saw clinical governance as positive is, as Bronwyn infers, again where local people were employed as project officers to implement the framework. Previously, often international advisors had travelled to Fiji, conducted workshops about 'quality assurance in health care', provided reports, and then left the country. Bronwyn is saying that clinical governance is different, and it is good, because professionals in the Fiji health services are taking ownership for implementation of the framework. In addition, from the nurse leaders' perspective, clinical governance has been a vehicle which they believe has enabled them to have more of a 'voice' in decision making around health policy and practice.

Being heard

The nurse leaders sense that they are becoming empowered can be understood in terms of Crotty's (1998, p.144) notion of institutionalized discourse, where discourse "constitutes an unusual form of communication in which the participants subject themselves to the force of the better argument, with the view of coming to an agreement about the validity or invalidity of problematic claims". Participants say that they are now being heard, whereas before they were a silent majority:

> *Nurses are the majority of the health workforce in Fiji. Their contribution is not recognized, formally* (Philomena); but

> *They invited us to go and present nationally…it was a beginning…one of the doctors there, one of the doctors commented on that presentation. Nurses have always been forgotten. Why? Why, when we are providing all this health care? Actually providing patient health programs. And the presentation actually highlighted the role of nursing and our contribution to health care* (Philomena); and

> *Because nursing is such a core, core function, you know. Nursing seems to infiltrate into this and that. So it's important that nursing is, it's part of this, you know, whole multidisciplinary area, multidisciplinary project* (Bronwyn).

The nurse leaders are describing a change in the institutionalized discourse of the Fiji Ministry of Health. If institutionalized discourse describes who gets their voice heard in Fiji, and given that "it is the institutionalization of the practico-political discourse that is the guiding light of Habermas's critical social theory" (McCarthy, 1984, cited in Crotty, 1998, p. 144), then this is a major issue for the nurse leaders. From a leadership perspective, this discourse – what is said, what is permitted to be said, who speaks, whose voice is heard, who is not permitted to speak, whose voice is not heard, is changing in Fiji. This is vital because whether this occurs in the Fiji Ministry of Health, or Queensland Health, or anywhere else, this institutionalized discourse informs all the practical/political questions that are able to be asked, and the answers to those questions. Unless there is the ability, as there is in this study, to reflect upon this tendency toward the technical control of people and processes, rather than a focus toward mutual understanding and emancipation ('being empowered' for these nurse leaders), then one dominant voice is going to continue to be heard, and the norms of a particular organization are going to suppress creativity at the expense of optimum provision of health care.

Habermas provides us with a clear view of a future that is not preferred in the absence of striving for an 'ideal speech situation' in this way. The nurse leaders of Fiji are saying their voices are now being heard at the level of discourse. They are engaging in more equitable debate about health services. Alice's comment about having her voice heard is also illuminating:

> *…in the beginning I thought- should I be giving, should I be sharing my opinion, am I allowed to do this? A bit in the beginning, but after being here for 2 years…I can confidently give it…what do you think about this, what should we do about this, and she asks me, you know, for my opinion, and I just give it. And I just feel good, you know…that I'm able to contribute.*

This notion of 'contribution' was important for all the participants and Alice's increased confidence about her role in contributing to health policy debate and decision-making reinforced the notion that the nurse leaders *were* becoming heard. Again, this is a vital point. Communicative action is always going to be structured by social and political rules (Forester, 1993), but the advent of health reform, in this case the clinical governance framework, meant that that the rules changed. Forester (1993, p.x) makes a case that the 'ideal speech situation' played less of a role in Habermas's project than the more pragmatic idea that what really matters

> …are the practical and institutional contingencies, the political vulnerabilities, of communicative action, not the abstract principles that might characterize anything resembling an inevitably counterfactual fiction of 'ideal speech'.

This is reinforced by Outhwaite's (1994, p. 45) comment that "…Habermas never intended the ideal speech situation to be understood as a concrete utopia which would turn the world into a gigantic seminar". The nurse leaders in Fiji are far from participating in such an environment. Nevertheless, the meaning fields developed around particular statements about 'being empowered' and later member checks to clarify meaning with the participants, consistently revealed that health reform and the introduction of the clinical governance framework, while not without its problems as will be discussed, was a vehicle which contributed to their sense of having an increased voice in the health system. This 'increased voice' was partly attributed to both the availability of basic and continuing education and also to new educational opportunities that were shared, particularly with medical doctors.

Education as opportunity

The basic nursing education system in Fiji has evolved dramatically during the last several years (Usher et al., 2004). As importantly for the nurse leaders, however, were opportunities to be educated for leadership and management, and attendance at health policy workshops with medical doctors. From a Habermasian perspective, this was an important finding. Habermas has "…come to focus on collective learning processes on the part of real historical individuals and groups, and to abandon the idea of an automatic link between these learning processes and social revolution" (Outhwaite, 1994, p.62). While it may seem something of a stretch to equate the nurse leaders sitting in a workshop in Suva alongside their medical colleagues with Habermas's notion of social evolutionary learning, I would argue that from a critical pragmatist perspective, this is exactly what mutual learning is all about. The group was not merely talking about the best way to implement the clinical governance framework, they were doing it *together.* As Edwina reminds us:

> *It is important. Workshops, attending workshops together with the doctors. Their development is such that they will be prepared more – multidisciplinary workshops rather than – nurses, oh they are nurses, they go and attend their own workshop. There should be no demarcation line,* ***it is seen that they are learning together.*** *So they attend a workshop, the doctors and nurses must, there should be more of that.*

Edwina's comment: 'it is seen that they are learning together' is of special significance. Following coding I took this segment and conducted a pragmatic horizon analysis, arriving initially at multiple meanings behind this foregrounded comment. Edwina was bringing a horizon into being that gives the message from a subjective perspective that 'nurses and doctors should be educated together because they are as good as each other'; and from a normative-evaluative perspective that 'if the people of Fiji see this happening they will get used to it and it will become what happens frequently in Fiji'.

All of the nurse leaders referred repeatedly to the opportunities that education granted them. Their certainty about this was a consistent theme throughout the interviews, and their determination to not only be educated themselves, but also to ensure all nurses in Fiji received optimum education, amounted to a passion. Bronwyn commented generally on the improvements in nursing education in Fiji, saying 'we've [nurses] come this far, you know our education has come, a lot of reward in the nursing education sector in this country'. While this is more about health reform generally rather than being limited to the introduction of the clinical governance framework, this theme was consistent with the nurse leaders noting that clinical governance had provided education and empowerment. It is therefore vital to link the two in this analysis in order to appreciate the wider 'system' aspect of nursing education in Fiji.

Alice's statement also reinforced this view of enhanced education:

> *And I think if any of us had not realized it we have really come a long way from the certificate level to the diploma, and you know, it all just seems to come, all come at once…having the Bachelor's program, the Master's program, and the postgraduate certificate in intensive care and cardiac nursing. And, you know, I'm just happy that I'm one of the leaders at this time of change in nursing.*

Clearly, the nurse leaders see education as being about more than their nursing role. Philomena's comment that 'women's role in Fiji has probably come up just lately. More visible, because of education. Really contributed to by education, you know, our role in society' is revealing. It is consistent with Leckie's (2000, p. 185) findings that "teaching and nursing trainees are predominantly women. Women may comprise over half the undergraduates at the University of the South Pacific but there is a

marked drop in female participation in postgraduate or advanced professional studies". One is reminded intensely of Freire's notion of *conscientizacao* (Fay, 1987), where nursing education can be linked with reflective processes, which are part of this study, for the nurse leaders. In this way they achieve both technical knowledge (which Friere referred to somewhat scathingly as 'banking knowledge') and the more crucial "ability to assess their situation critically with a view toward changing it" (Fay, 1987, p.106) as they seem to be doing.

Dorothy spoke of her perception of more equal relationships that are evolving between the younger generation of nurses and doctors in Fiji and suggested the reason for this as 'their exposure, academic, ah, academic achievement'. All of the participants mentioned the increased assertiveness of nurses who had completed a nursing degree program: 'they are so outspoken. You know, they question things and I **love** that' (Dorothy). The issue of education can also be problematised however. While the participants universally spoke of the benefits of education, there were several comments that revealed educational opportunities could also be the basis for concern, in terms of inequities of opportunity for nurses in Fiji. Dorothy and Coral both referred to an historical event in the history of nursing education in Fiji. They described a 'New Zealand' curriculum that was offered alongside the 'local curriculum' in the 1960s and 1970s. Some students were placed in the higher status 'New Zealand' curriculum and these were evidently nurses whose careers were subsequently fast-tracked, so that they achieved leadership positions in nursing first. Dorothy had been a 'New Zealand' curriculum nurse, and I asked her how that had happened:

> *Mm. Come to think of it, I don't really know how I got into the New Zealand class. Maybe it was on academic, academic results from school…there was an interview also, now I come to think of it.*

Coral, the youngest of the participants, had stronger views about the New Zealand curriculum, and spoke of how the system has changed in recent years:

> *…things have changed a lot in the last couple of years. And usually, I knew very well, if you're colonial class, a colony class, you get the lower hand…The New Zealand class gets the upper hand…It was the curriculum they used at the time. So there was, in an intake, there were, you get the field to do the New Zealand Class program – and the colony class, the Fiji class…so it came to a stage when the New Zealand class, may I say, the symbol was very strong. If you performed or did not perform as long as you were in the New Zealand*

> *class, you get the upper hand. And that didn't do well with me. As a young person…in our time we were all in the colony. No more New Zealand class. It ended in the 1970s.*

This reference to 'symbol' is significant. From a 'micro' or interpersonal perspective, the creation of this system contributed to tensions among the local nurses as they sought promotion in their professional lives. From a 'macro', or sociopolitical perspective (Scambler, 2001) the lifeworld of nursing education was colonized by the development of a divisive system, however inadvertently. Once again the 'voice' of British colonization had lasting impact on the life of Fiji. This serves as an important example of, as Greenhalgh, Robb and Scambler (2006, p. 1171) point out, Habermas's contention that "when economy and state intrude in inappropriate and unaccountable ways into the lifeworld they can be said to colonize it". Again this is a timely reminder of the possible impact of international aid in developing countries.

There is a clear link between perceptions of differing status that can be made in the New Zealand class/colony class divide and the more recent doctor workshop/nurse workshop divide. Edwina wants nurses and doctors to *be seen* attending education experiences together; Coral continues to view the New Zealand class as the perception of a symbol of higher status, no matter that she disagrees with it. Arguably, differences in status will always be at odds with the likelihood of communicative action and will interfere with the possibility of the ideal speech situation. For the participants, introducing the clinical governance framework meant that they were being educated alongside the doctors, they were developing policy and taking responsibility for implementing it from a multidisciplinary perspective. Part of the reason for this may well have been that the Director of Nursing was also the Director of Health System Standards, which meant she was responsible for clinical governance, and had the power to organize consultants and nurses in the way that she wanted this to happen. It is revealing, nevertheless, that in 2003 (Stewart et al, 2006) she was given the task of coordinating standards across all of the health disciplines. I had the opportunity to either facilitate or attend many of the clinical governance related workshops at the time and my field notes attest to the level of healthy debate that involved *both* nurses and doctors at these meetings. For the nurse leaders in this study, however, an equally important issue concerned who was at these workshops

because it related to perceived restrictions on younger nurses achieving leadership positions.

Doing our time

How older people are perceived in Fiji society is perhaps contrary to the Western view of the elderly. Nurses nearing retirement in Australia have been traditionally hastened out of the workforce and generally seen to be 'past their prime' at a relatively early age. Notwithstanding the impact of the baby boomers nearing retirement and the current nursing shortage, where this discourse has altered overtly, the covert reality is that younger is seen generally as better in Western society. Hardcastle (2004, p. 118) addresses the issue of ageism in nursing, noting the nursing profession's "shared assumption that mature novice nurses" are perceived as adapting less well to renal technology. This common assumption is problematic, but somewhat different in Fiji.

Coral spoke of how older people are perceived in Fiji, and she linked this noticeably to the Fiji nursing culture:

> *It's our culture that we get to listen to the older people, the elders, and that has interwoven in most of the things that we do, even professionally. And mostly, because we are all much women, there's so, well the majority are women in nursing, it's much stronger in that area. It's almost like the male dominance…in our culture. So the male dominance in our culture is similar to the seniority dominance in whatever we do in nursing.*

Irrespective of the age of the participants at the time of this study, the majority referred to this process as 'doing your time' in order to achieve in nursing. This was about being given opportunities for education and being promoted within the nursing hierarchy. Again, this is a crucial element of the 'macro' social structure of nursing in Fiji and was therefore extremely significant for inclusion in the analysis phase of the research. The introduction of the clinical governance framework proved to be a major element of the wave of reform that was occurring in the Fiji Ministry of Health just prior to and during the time of this study. The study proved to be an opportunity, so the participants informed me, to talk about how the reform had affected their lives as nurses in a number of ways, including changing the tradition of sometimes waiting for many years for promotion within the service.

At this stage, I will turn to an example of text from Coral's interview, then compare that with the same theme from the interviews of the other participants. This will illustrate effectively not only the participants' views about the problem of 'doing your time', but will also illuminate briefly the analysis techniques used throughout the study. It is important to remember Carspecken's (1996, p.94) point that any "reconstructive analysis is at heart a creative endeavour, akin to the creativity involved each time we understand other people in everyday life". In this sense analysis remains initially tentative and must involve member checks and peer debriefing among other procedures to minimize researcher bias.

One participant is speaking of how she achieved a nursing leadership position in Fiji:

> *It was after five years. But I knew I was not going to break the barriers if I stayed at a major hospital like CWM. Which was very attractive at the time. You were in the city. You had all your friends here. So what I did was, to be able to break the barrier, was to look for, I had to look for where the hierarchy was thin. You know what I mean. So, what I did was I chose to go out to the Islands.*

Although the other participants spoke of 'having to do their time', while one referred to 'getting past the barrier of having to do your time', it can be seen that action patterns are the same here. The participants all indicated that a normative-evaluative element in Fiji was respect for elders, which was then linked to the empirical claim of needing to be older in order to achieve a higher status in Fiji nursing. In order to reconstruct this single piece of text, I reviewed this participant's story about becoming a nurse leader in Fiji at a relatively young age, which she again claims is unusual in Fiji. She said, for example '… I wasn't going to wait for another fifteen years to get promoted to Sister'. She used different words which conveyed more possible meanings: 'to get here I was very unpopular'; 'leaders don't seem to take you seriously'; '…it's the culture that's already in here, and someone just has to break it'. The meaning field for this sample tentatively looked like this: 'Fiji nursing has a hierarchy that must be broken'; and 'It is possible to break through the Fiji nursing hierarchy'; and 'It takes a lot of personal effort to break through this hierarchy'; and 'One must be very strategic when going about breaking through this hierarchy'; or 'Only older nurses normally achieve senior positions'; and 'In Fiji nursing culture, we normally only give older people power'.

When articulating a possible meaning field around this segment of the interview text, it was also crucial to review my field notes about the participant's body language and other comments about the interview. Carspecken (1996, cited in Kincheloe and McLaren, 2003, p. 468) contends that "…critical ethnographers record body language carefully because the meaning of an action is not in the language but rather in the action and the actor's bodily states". My impression of this participant's body language included the notation that 'she is very assertive with me [the researcher]. She sits comfortably in her chair, with a very open posture; she leans towards me, seemingly to emphasize what she is saying; she uses my first name frequently when speaking; she interrupts me confidently but politely whenever she wants to make a point or seems to disagree with something I am saying. She speaks quickly and there is a lot of energy around the way she conducts herself'. Using Carspecken's notion of becoming clear about my own cultural typifications in terms of recognizing possible meanings, I was cautious at the time about the fact that I felt empathy for this participant's more individualistic approach to her career, which seemed more Western than the community focus in Fiji that I had been reading about when reviewing the literature.

Grbich (2004, p. 69) reminds us that the researcher "…can be located spatially, culturally and within the research process in similar or different places from the participants". The relevance of this point continued to be crucial throughout the study, as it was at this stage where I compared this participant's comments with those of the other participants and with my observations in the field. Dorothy referred to waiting for opportunities as going through a 'grinding mill':

> *In Fiji – is – come through the, come through the grinding mill from the (laughs). I've done, I've had to do, what, almost 30 years of work before I was given the opportunity to do my degree, all that.*

Bronwyn referred to this as 'the ranks and files': 'everyone has to go through the ranks and files, so to speak, eh'. I made specific comments in my reflective journal however, that Bronwyn's subjective state and her body language when telling this part of her story seemed to differ from that of the other participants. The inference from Bronwyn was that 'it is good to have to go through the ranks and files. Everyone should have to do this'. Whereas the other participants, many of them at the same late stage in their careers as Bronwyn, talked about 'doing your time' as perhaps

historically appropriate, they indicated this was no longer valid for the 21st century. This difference should be considered in terms of the issue of cultural power. Carspecken (1996) reminds us that when claims to universality (that is everyone in the social group agreeing that a normative-evaluative claim is valid) fall short, cultural power is at play. So "when one cannot fully recognize one's self, one's own interests, within an articulated norm or value, then one would only consent to this norm or value because of the play of power" (p.145). Another way to think about this is to consider the particpant's situation as a younger leader, and how it would have been for her to have agreed to wait the suggested fifteen years to be promoted. In this case, cultural power would have been an issue.

For Edwina, Philomena and Dorothy, health reform should be linked to new opportunities for aspiring young nurse leaders. Dorothy said '…some are ambitious yes. They go out of their way to do extra studies. And they're people who have done extra studies at USP [University of the South Pacific] and Central Queensland'. Dorothy also spoke of the problem of losing some of these young aspiring nurse leaders from the nursing profession:

> *…And the next thing I hear is that they are applying to do postgraduate studies at the Fiji School of Medicine. They are very young. I just hope we don't get to lose them. Some who get frustrated. They are ambitious and then they don't get what they want. And these are the ones that we tend to lose. Sometimes I don't blame them. Sometimes I say 'oh, good for them'.*

Edwina expressed her hopes for the future of nursing leadership in Fiji:

> *I want to see younger people, Lee, move on to be the Director when the Director of Nursing goes…if they have a young, dynamic one who has come through, with experience, and she knows how to talk – not necessarily for you to become Assistant Director and then Director. At this level…I see – if I can see somebody here who can take the job, I'm supportive of her. [They] shouldn't have to wait until they're old…*

She went to state explicitly that she did not see this view as ageist: 'I'm not saying that age is bad. No, Lee, I don't think like that' but rather as the possibility of equity of opportunity for competent aspiring leaders, no matter what their age.

Consistent with this theme, Philomena makes a case for assertive young aspiring nurse leaders:

> *And that's what we are attempting, that we would like to ask our young nurses 'what do you think?' Contribute. Most of my sisters-in-charge are from the*

> *older age group, some of them are older than me. They've come through a culture of they just take it all. I'm trying to help them realize we need to hear our voices out. We need to encourage them [young nurses] to contribute effectively and include them in what we are doing. And I would like to encourage young nurses to think and think and look at solutions, explore, look outside the box. Because the environment is so dynamic. And from tomorrow and the next years it's only going to be more dynamic in nursing. And nursing for the future has got to think outside the box.*

From a Habermasian perspective it can be seen that the lifeworld of Fiji has been partly about respecting older people in the community. The nurse leaders are problematising this aspect of lifeworld which is fascinating, as they *want* a system, within nursing at least, which is different from everyday life in this country. Using Carspecken's technique to analyse this and other themes for this study allowed me to consider each actor's statements in light of this. Following preliminary reconstruction, I was then compelled to undertake a pragmatic horizon analysis surrounding this whole idea of the *meaning* of age in Fiji society, and particularly in the culture of nursing in Fiji. The key to this was the impact of reform (such as the introduction of clinical governance) on these nurse leaders, ultimately upon nursing and even possibly on the wider society.

Pragmatic horizon analysis, which has been described in detail earlier in this thesis, allows us "to unpack leadership [which] allows us to recognize factors that have impacted on nursing leadership and made it what it is today" (Stewart & Usher, 2007, p.994). The horizon for this theme caused me to ask the question: is it oppressive to have to wait for nursing leadership until one is older?

It is necessary at this point to be reminded that pragmatic horizon analysis is about the fact that we cannot understand ideas in the world without simultaneously understanding the 'horizon' from which that idea emerges (Carspecken, 1996). Conducting a horizon analysis for a segment of interview text is therefore a complex process. It was necessary initially to position the participants and myself as the researcher within the geographical location that was the site and locale of the study. The site for each of the interviews had been the participants' offices or nearby meeting rooms. However, the sites included in the study are various places throughout Fiji's health system. Whatever took place in the interviews, and indeed, in the Head Office, hospitals and health centers where I spent time with participants was

influenced by the locales and social systems in Fiji. Fiji's pre-colonial, pre-Christian history was influential here, as was the period of colonization and the introduction of Christianity; the introduction of indentured Indian labourers to the country and current Indo-Fijian/Indigenous Fijian relationships; Fiji's situation since gaining independence; the coups and their effect on the country; women's role and status in Fiji; the effects of globalisation; and the current sociopolitical and economic situation in the country.

The actors who are the participants in this study were subject to these influences in Fiji. Such influences then had a relationship with the validity claims made by the actors. Coral made her claims, as did the other participants, against the social, cultural and political background of *their* world. The claims of these actors then had to be foregrounded against the 'horizon' which surrounded and were behind them. For Carspecken (1996), this horizon encompasses a range of claims that are around and behind the act. In the example from Coral's interview, therefore, where she says '…I wasn't going wait for another fifteen years to get promoted to Sister'; a meaning field had already been partially constructed. This tentative meaning reconstruction laid the groundwork for undertaking the horizon analysis. The meaning of age for the nurse leaders in Fiji gives some indication of the identity claims that were made by the group, which in turn assisted me to gain a more meaningful insight into the world of their health care organization.

Considering the pragmatic horizon, in the foreground was the explicit claim that young aspiring nurse leaders should be given earlier opportunities for leadership. A pragmatic horizon, as has been stated, has both a paradigmatic axis and a temporal axis (Carspecken, 1996). In this example, along the paradigmatic axis, the actors were making a number of claims. In terms of a claim to intelligibility, we all shared similar linguistic symbols around the meaning of 'age'. The claim for legitimacy was, I believe, about participants acting strategically rather than communicatively; it was apparent that they had an intention to influence changes to the perceptions around age and nursing leadership. Their subjective states (relating to feelings and intention) were an enthusiasm and serious intent in what they were saying about the subject. Identity claims seemed to be that they were good, well-intentioned nurse leaders and indeed forward-thinking and admirable people. Reference to the objective state of

affairs was obviously a shared knowledge that being older meant being more powerful in Fiji, but that this was beginning to change as a result of health reform processes. The temporal axis is about a shared time consciousness and "one must note the location of the act within the participants' awareness of prior events and within the expectation of events about to come" (Carspecken, 1996, pp. 105-106). The meaning of this act was closely associated with a shared understanding that older age has equated with greater power and influence in Fiji and that this was reflected in the nursing hierarchy.

There was also a perception that things were going to be different in the future, and that younger people would have increased opportunities for nursing leadership positions. Concerning horizon analysis, I also ask the question 'so what?' as Carspecken does in relation to meaning reconstruction. The answer is a need to discover the *point* that actors are making in a given situation. Here I needed an understanding from the insiders' perspective about the impact that health reform (more specifically the clinical governance framework) was having on the discourse of nursing leadership in Fiji. What will it mean if nurse leaders came into their roles with longer careers in front of them? What might that cause us to discuss about nursing leadership in Fiji, which we were not necessarily discussing in this study? Coral's experiences, as a younger nursing leader who seems to sometimes struggle with traditional values, are supported by Leckie's (2000, p.178) view that in contemporary Fiji society "even the most progressive women eventually confront 'old realities', not just from the past but as daily realities in the present". If younger nurse leaders emerge as part of health reform, how will that change such realities?

The insightful analysis possible in Carspeckian methodology was revealing, as can be seen, as it was applied across the range of themes that emerged from the rich evidence captured both at interview and during my time in Fiji working and living with local health professionals.

Empowerment and The Fiji Ministry of Health as a system

Carspecken (1996, p.206) contends that it is his "stages four and five [that]…give critical qualitative research its specifically critical bite". Validation requirements for

stage four have been described in detail in chapter 3 of this thesis. Suffice to say that it was actually impossible to conduct this study without some degree of systems analysis, and to include elements of this in the final report. The nurse leaders lived and worked at a number of different social sites which were part of the social system of the Fiji Ministry of Health. The conducted their personal and professional lives in different parts of the country, providing leadership for major hospitals, community health services and beyond. Professionally, they were both influenced by and had influence on the way that health care was delivered throughout the Fiji Islands. I was compelled to include consideration of the organization that was the Fiji Ministry of Health during the time of this study. The Ministry of Health in turn was influenced by economic and political issues in Fiji. In addition, international developments in nursing and in health care delivery in general obviously had to be considered concerning their influence on Fiji and Fiji nursing.

Consistent with Stage Five requirements, the findings for this study have been interpreted throughout in terms of Habermas's macrosociological theory of communicative action. During my time in the field, an event occurred which served to assist with analysis. The key issue here was that this event mirrored the sort of comments the nurse leaders were making about the need for the people of Fiji, rather than 'non-locals', to have control over health care policy and practice. During one week in 2005 I attended a meeting which was particularly illuminating. Those attending were all members of an international aid program and included external advisors from an Australian aid agency and local Fiji leaders, including the indigenous Fijian Director of the aid program and the Director of Nursing for Fiji. The intention of the gathering was to show an example of a videotape made for the aid agency staff, which was intended to improve their understanding of local cultures and to educate them about how best to work with the people of the South Pacific. The mood was congenial and there was praise for the videotape from all participants. During the same week, however, a concern was raised by the Ministry of Health's Chief Executive Officer (CEO), also an indigenous Fijian. He commented that the 'International aid agency advisors seem to be running the Ministry of Health, rather than me and my team, and that is going to change' (field notes, 2005). While speaking with those working in the Ministry of Health at the time, including the external advisors, two themes emerged. First was a belief that the work of the

international aid agency advisors was useful and that the forces for change in Fiji were assisting the country. The second was a strong view from local people that the advisors were only there to assist, but that the 'locals' should make final decisions about what was to happen in the Ministry. These themes are consistent with Habermas' concession of giving a bit of "…ground to functionalism in that he accepts that some degree of systemic steering is necessary in order to manage the complexity of modern lifeworlds" (Ray, 1993, p. 48). Nevertheless, he also identifies that such 'colonization' "…requires new forms of democratic participation aimed at curbing economic and administrative power". Clearly, the CEO, his local team, and the external advisors were in an interaction that did result in a redistribution of power within the Ministry over the next six months. The whole notion of power was obviously central to this study and as the researcher, I remained cognizant of Kincheloe and McLaren's (2003) concern that

> there is a risk that uncovering colonial and postcolonial structures of domination may, in fact, unintentionally validate and consolidate such structures as well as reassert liberal values through a type of covert ethnocentrism. (pp. 462 – 463)

Again, the analysis of the nurse leaders' stories revealed a match between what they were saying and events in the wider system of the Fiji Ministry of Health. My vulnerabilities as researcher were around this notion of whether I was, in fact, as *kai valagi* rather than *kai viti*, not really entitled to be in Fiji conducting this research. This continued to be of concern, I noted in my reflective journal, as I analysed the data and attempted to deal with my own dissonance about whether I was 'doing good or bad' with the research, whether my presence was constraining, empowering or merely neutral for the nurse leaders. Nevertheless, it was apparent, as will now be discussed, that the nurse leaders' sense of increased empowerment was to have a positive effect on the nursing profession and consequently for the patients of the Fiji Ministry of Health.

Chapter 5: Legitimizing our role as the facilitators of best patient outcomes

As has been discussed in the introduction to this analysis, the empowerment of the nurse leaders meant that they became increasingly engaged in communicating with and improving the conditions for nurses throughout Fiji. This was inclusive of considering staffing levels, skill-mix of the staff and consideration of the Scope of Nursing Practice, and environmental conditions and economic reward (wages) for the nurses. Obviously, as will be demonstrated, improved conditions for nurses results in enhanced care for patients. Of crucial importance is the belief, which is supported by the work of Kalisch and Aebersold (2006), MacPhee, Ellis and Sanchez McCutcheon (2006) and others, that the betterment of nursing results in safer patient care with a reduction in adverse clinical events. The Pacific Plan for Strengthening Regional Cooperation and Integration (Pacific Islands Forum Secretariat, October 2005) includes the key Strategic Objective: 'Improved Health' for the people of the South Pacific nations. Fiji is a member country, and the Secretariat's Regional Priority of 'Good Governance' provides a clear link between improving the health of the people of Fiji and sound clinical governance for health services. For the nurse leaders, the obvious connection in this study was between more effective nursing practice and an increased focus on patient safety and good patient outcomes.

Sheps (2006), in comparing health care to the nuclear power industry, notes that while society has a dread of nuclear and other industrial accidents, this same 'dread factor' is not currently applied to the problems inherent in delivering health care:

> Although dread is compelling as a motivator, it should be clear…that, from national studies of adverse events over the last ten years, health care, while less spectacularly harmful, is nonetheless producing harm to greater numbers of individuals in any one year than all these other industries put together. (Sheps, 2006, p.142)

Fiji is no different from the rest of the world, in that health professionals are constantly confronted with their limitations when things go wrong for their patients. The nurse leaders in this study identified that they knew there were problems in delivering health care. They spoke of a past system which was focused more on health professionals and their needs than it was on patients. One of the participants, Philomena, said: 'That's the way it is here. Because you sit on national forums on occasions, on budget meetings, **it's all about the staff. What is it about the**

patient?' However, they also noted their beliefs about what a clinical governance system could do for their people:

> *[Clinical governance] should improve health services, especially the quality of health services that we have, the quality of health care that we are giving to our people…and at the end of the day it will be our customers, both internal customers, the workers, and the people who are the recipients of health care, who will be satisfied with the kind of care that we give them.*
>
> (Alice)

Alice refers to 'internal customers, the workers', and all of the participants made constant reference to the connection between improvements for nursing and improvements in patient care.

Having the 'heart' for nursing – understanding the nurses

The nurse leaders in Fiji told me that they had been generally a somewhat passive group, in the Florence Nightingale tradition, and they did not want that for their future. At the heart of a "critical ethnography [such as this one] is the constant use of negation – trying not to see things as natural or rational but as exotic and arbitrary, as an expression of action and thinking within frozen, conformist patterns" (Alvesson & Skoldberg, 2000, p.140). As a nurse as well as a researcher, I had been the recipient of dominant medical discourse for most of my professional life, so share this perception (or bias, perhaps) with the participants. This taken-for-granted idea that nurses are somehow less than their professional colleagues is a dialogue that persists in the health professions, despite the rhetoric of more equal relationships. The notion of medical dominance has been comprehensively addressed from a Habermasian perspective concerning doctor-patient relationships (Barry et al., 2001; Greenhalgh, Robb & Scambler, 2006; Hyde & Roche-Reid, 2003; Mishler, 1981; Scambler, 1987). Less attention has been paid to doctor-nurse interactions considering the probable absence of an ideal speech situation. For Baillie, Smith and Broughton (2000, p.448), "Habermas's theory is constructed around the need for communication that is free from domination and distortion among individuals and groups having differing values, beliefs and practices". Where such distortion does occur, it translates, from the perspective of a health care organization, into one group having more than another of necessary resources as well as an equal 'voice' in health care decision-making. For the nurses in Fiji, this has translated into less educational opportunities, poorer

working conditions (Serelini, *Fiji Sun*, January 22, 2007) and a general sense at times that 'the nurses are at fault concerning poor patient outcomes'.

This frozen and conformist discourse is changing, albeit slowly, and the participants saw this change as a way forward to better patient care. The analysis of these interview texts also had to be considered in terms of what it meant to be a 'nurse' or a 'patient' in Fiji at the time of the study. We are reminded that "neither God nor nature" (Alvesson & Deetz, 2000, p.101) make a 'nurse' or a 'patient'. Rather, explorations of such terms should always cause us to ask questions (to paraphrase Alvesson and Deetz) such as 'What is a nurse really? What is the essence of a nurse? What makes one a nurse?', knowing "these are not answerable by looking at the something that can be described as a …[nurse]; they are the product of linguistic and non-linguistic practices that make this something into an object" (p.101). If this is so, and if constructs such as 'nurse' or 'patient' are ever-changing, then the nurses of Fiji live with the possibility of change for the better in their health service. The construct of 'nurse' as something less than healer should be considered in light of Habermas's distinction between communicative action and strategic action. One might theorize that this construct is arrived at through the use of 'communication pathologies' (Greenhalgh et al., 2006). This can mean that, over time, such generalizations surface and are reified through a continuing stream of distorted communication (whether conscious or unconscious) that requires the healthy debate of communicative action for resolution.

Knowing the nurses

Philomena's opinion was that nurses could become more empowered and could be construed in a positive light as healers and patient advocates. She said to develop the best sort of nurses, she had to know them well:

> *In your days, be with them, talk with them. People might say "do you have time for this?" No, but you really need to walk more, in and out of the wards, just to be with the staff. And along the way you can create informal dialogue – I believe very strongly, today in Fiji, for nursing.*

The participants continued to make (sometimes tacit) links between improved conditions for the nurses and better patient care. It was crucial to concentrate on what they were saying about current conditions for nurses and what they were either doing,

or thought the Ministry should be doing, to improve these. From a wider 'system' perspective, they said that if the nurses were more empowered at work, they would give better care to their patients. This can be considered from the understanding that people will possibly engage in less than optimum activity, even oppositional activity, if their good sense of themselves, their sense of identity, is threatened. I have already discussed the nurse leaders' notion of their history of passivity, and how they wanted that to change. They felt that it *could* change if they as leaders went about supporting and developing the nurses in new ways, given their own increased sense of autonomy. They spoke of their own hierarchical system, noting that this had contributed to nurses not necessarily challenging norms:

> *Perhaps it's the culture, not to answer me back, respect me when I say something…yeh, but for leading the kind of nurses under me here, Lee, I think I'm a bit, ah, for now, when I say something, they don't question me. It's like – it's OK. At the same time, Lee, the quality of care is not, why I'm saying this, perhaps the quality of care is compromised here [because of this]* (Edwina) and

> *Nursing in Fiji has come through whatever comes from the top. I would like nurses who can* ***challenge.*** *Challenge in a constructive manner. You want people to* ***think*** (Philomena)

At the time of the study, this generalization about nurses as 'not thinking' and 'not challenging' was prevalent among the nurse leaders. They indicated that medical doctor domination contributed to this problem: 'And in Fiji we have evolved – and, what is it, doctors were – dominating…and nurses were still down, underneath' (Philomena), but that the nursing culture was also a factor. Dorothy noted that it was often difficult for nurses to approach their leaders: 'I have to do it for my other colleagues, because, ah, her staff feel much more comfortable coming to me'. For Coral, this perceived 'distance' between the nurses and their leaders can be changed through the leader's initiative:

> *Influencing people in a different way. Influencing people through leading by example. Not much talk – you do it. If I want to change something – I was a very senior nurse – if I want to change something I do it the way I would expect others to do it. If I come into the ward and the thermometer is not soaked in the way it was supposed to be soaked, it's dry. I don't have to ask: 'who was that nurse?' But I do what I need to do. And people would just follow, you know, without having to be given the unwritten rule or whatever. People would just follow…the other strength that I believe has got me here is, you can always tell, you can always feel the heartbeat of your subordinates. While you're very strict, you're very professional; you can always feel the*

heartbeat of your subordinates. ***And that is something that most of us do lack****.*

The important issue here is that the nurse leaders are thinking and talking about desired changes to the way nurses function within the Fiji Ministry of Health. An absence of this kind of reflection might indicate, as Alvesson (1996, p.64) suggests, a situation where "managers…may be subordinated to cultural ideas and values which they take for granted". If the nurse leaders *were* sincere in their utterances, remembering that claims are always subjective and the audience (in this case, me) has only privileged access to this subjectivity, then the nurse leaders were moving beyond this 'taken-for-grantedness' concerning cultural power. Note that Coral talks about 'feeling the heartbeat' of the nurses. When questioned about this she said: 'you're considerate…and sometimes people are very unhappy, you can always see'. She gave an example:

> *OK, for example, this nurse comes late every day…It's pointless for you to punish her because she is coming late. And she might have reasonable reasons for coming late. Maybe she's got a young baby at home; her husband is not very supportive. She has to do all the household work before she comes to work. She can be tired. So what I can do is "OK, how about you come onto afternoon shift instead of morning?"*

The nurse leaders talked about knowing their nurses and responding empathically to their concerns as a key to improving the situation for them. The construction of meaning fields and pragmatic horizon analysis on this piece of text and on other similar utterances by the nurse leaders, caused me to note that they talked about not only developing the nurses to be their best, but also about being the best sort of nurse leaders themselves; Coral obviously refers to role modelling when she mentions the need for 'not much talk – you do it', adding 'I can be yapping and yapping and I'm not delivering, it doesn't make things, it doesn't make things better at all'. Alice said:

> *I would just walk through the ward – at night I'd just be walking through the ward encouraging and thanking people who were working. And they would say 'Oh, Sister, thank-you for coming around' and those kinds of comments. And that made me a stronger person, and they respond positively, yes.*

The message from the nurse leaders was one of taking action in order to improve the situation for nurses and patients. Another example provides a further illustration:

> *People will respect you if they know you are doing the work. It might be the one in charge is one who sits all the time, just does the time and doesn't stand*

> *up. At least, if the ward is busy, you know, attempt to be giving the drugs or at least make a bed or something like that. Then she talks about something in a meeting, hardly people listen. It's like actions speaking more than words* (Coral).

'Walking around the wards', 'having an open door' and 'being more visible in providing leadership' were consistent themes from all the nurse leaders. Creating less distance between themselves and the nurses indicated a desire to be seen to be acting ('doing it' as Coral said) with and on behalf of the nurses and the patients. From Philomena: 'this office is no longer shut tight, no', from Edwina: 'for me, the way I see now my nurses come to see me at any time' and from Dorothy: 'I have an open door – I like to see my nurses, because I feel I am here because of them'.

The challenges of 'distance'

In contrast to the nurse leaders speaking of an increased sense of proximity to the nurses, some indicated that this had not yet been achieved throughout the Ministry. This was seen as an impediment to the introduction of clinical governance:

> *Sometimes it's always difficult, the planning phase is difficult, and when it's ready for implementation then you get: "oh, we didn't see it this way, you didn't tell us it was gonna be this way". So I think, in terms of nursing, one of the major things that clinical governance framework and the things that's got to be in place is to get, from all levels of nursing, from the top to the very young nurse, they must be able to know what clinical governance is…and sometimes it can stay with the top people, it doesn't go down to the people that are on the ground* (Coral).

The inference from the nurse leaders was that communication needed to occur at all levels in the Ministry, including Head Office, in the same way as they were communicating with the nurses. Alice said: 'there's a lot of hard work that needs to be done to really get it off the ground', but she also expressed confidence in the Ministry's ability to do the work. Bronwyn felt that the nurse leaders would continue to be the major facilitators for decreasing 'distance' at all levels in the Ministry: 'So to me, it's what I do to try and improve the system, to improve the lot, to improve the services for, you know, the nursing service or the health service, eh, in this country'. Philomena felt that effective nursing leadership would provide a focus for all nurses in terms of improving patient care through the introduction of clinical governance:

> *We'll get there provided [there's] good leadership, good leadership and good managers, good management, good practice. We should be able to manage the resources, the scarce resources we have to provide quality care. These are*

> *all about good leadership, eh? Leadership is the key thing to get there. We may have a good system, but with poor leadership I'm afraid it will cause problems, and frustration. That's one thing about introducing any change, any new thing.*

All of the participants linked this notion of good leadership to providing adequate resources and a sense of empowerment for the nurses of Fiji.

Providing for the nurses

It was clear that the participants perceived a major role for themselves in terms of empowering and advocating for the nurses, so that the nurses in turn could empower and advocate for the patients. One of the participants describes a situation of environmental risk for community health nurses:

> *You know, they said 'we are working in this environment. There's this land behind us that's exposed to landslide and there's a mango tree'* and from another

> *Because we looked at health programs – we would like programs packaged so that when a nurse go out and deliver [patient care]…with provision of their transport, safety in their workplace. As well as when they are out in the rural areas they are provided with secure homes. And maintain the communication, for them to communicate with the base hospital…as nurses, focusing on quality improvement [for patients].*

What the nurse leaders actually *do* for the nurses in these situations is vital here. Returning to the notion of Habermas's validity claims as we must throughout this study, consider Scambler's (1987, pp.167 - 168) contention that the only justification for "…the comprehensibility and sincerity of an utterance can be…through rephrasing what is said or through consistent behaviour (for example keeping promises) respectively". There is an inferred promise from the nurse leaders here that they will engage in improving working conditions for the nurses. Certainly their actions at the time of the study indicated sincerity around this promise. For example, there was much discussion about the ideas of coaching and mentoring nurses to enable them to be the best that they could be professionally.

> *I, I am encouraging nurses, encouraging nurses. When you come out of the School, we'll give you orientation and [you'll] be able to know what's happening in the hospital, and brought into community health for at least 2 years, the first 3 years of your nursing education complete, you know, the foundation so that you'll be able to identify where you would like to pursue your career in nursing, we'll teach you all that. And when you come back and*

> *want to specialize. As you move on, whether you want to be a clinician, or go into education, or go into management* (Philomena) and
>
> *…I would get them in and sort of share [with] them and try and lead and all that, eh, the courses and all sorts of things, eh. I have a plan, progression plan for the nurse leaders…and even to prepare for their development. Develop them and tell them the courses they need to do – and try and do that in the hope that they know that they will take on the roles, eh. The people that I work with, immediate subordinates here, ah, I sort of you know, I groom them* (Bronwyn).

The impact of health reform, including the introduction of the clinical governance framework, was important here. I had the opportunity to visit the areas of the Fiji Ministry of Health where participants practiced as leaders and managers for large groups of nurses several times over the course of this study. My field notes reveal an impression that the nurse leaders who function in the hospitals and community health services are very available to the staff, more so than my experiences in Australia. Their office doors *were* open, and I observed many examples of greetings from nurses and occasions when they would stop and have detailed conversations about some aspect of a nurse's concerns or a patient problem. The distinction between lifeworld and system is crucial here. The hierarchical system of nursing previously alluded to, with its basis in Nightingale's British system, was introduced into the lifeworld of Fiji. This system persisted over time, and it is only now, with the introduction of yet another system, that the nurse leaders are questioning the validity of *all* Western systems. To explain the lifeworld of Fiji prior to this colonization, and what is happening now with 'open doors', one can turn to traditional indigenous Fijian ideas of being available for others. Katz (1999) describes customary Fijian ideas of

> respect for others [which] leads one to *loloma*, or the feeling of love or kindness for all others, just as the feeling of *loloma* engenders respect. To possess *loloma* is to recognize all persons as worthy of honor, care and kindness. Solidarity is the aim; caring for others, the means. (p. 29)

It is probable that the nurse leaders felt empowered to once again express *loloma* for the nurses, rather than feeling obliged to follow the colonizing system. Less obvious was the relationship between nurse leaders from the Head Office and the rest of the nursing workforce. Visits by these leaders were more formal occasions and the espoused 'nursing hierarchy' more in evidence. Nevertheless, there was consensus among the participants that nurse leaders at all levels were closer to the reality of nursing practice than they had been prior to the reform.

It is vital to contextualize this new 'open door' policy, the links the nurse leaders made between being more available and better coaching and mentoring of the nurses, and the introduction of clinical governance. The nurse leaders did *not* say that coaching and mentoring of staff was absent before the introduction of the clinical governance framework. Clearly, although they gave examples in their own careers where such support was lacking ('A lot of time we've been allowed to sink or swim' - Dorothy), the advent of reform had in effect enhanced their *awareness* about the need to provide more formal mentoring. As Philomena points out: 'Succession planning. I'm doing that informally. We give an opportunity for others, we do that informally'. Coral similarly linked mentoring with succession planning when she said:

> *I never used to think that I could mentor, but that came with leadership. It's really nurturing and mentoring and knowing that successively when you lead there's someone to walk into your shoes. You're not leaving, ah, shoes that no-one can fit into.*

For Dorothy the issue is that 'the immediate supervisor is given that role to mould and to start to train' the nurses for whom she is responsible. Bronwyn spoke of mentoring subordinates, indicating that this was not always successful: 'You know how the saying goes – you can only lead a horse to the well, but you can't make the horse drink!' This was significant; the nurse leaders were engaged in providing support for the nurses, but the inference was that the nurses could agree or otherwise to participate in such dialogue. Concerning communicative action, this illustrates the possibility of an ideal speech situation, where leader and subordinate had the right to accept or reject the mentor relationship. A further example here occurred around the issue of nursing uniforms, particularly the wearing of the nursing 'cap'.

Wearing the uniform

One intriguing aspect of this study was the symbol of the nursing uniform as worn by the nurse leaders. Edwina is describing a situation where senior nurse leaders began to wear civilian clothes to the workplace:

> *…if I continue to wear that formal cape, do you think they'll report matters to me? No. they won't. Because if I am easy with them they are easy…in these clothes, yeh. 'Good morning, ma'am, good morning'. They are comfortable to converse with me. And you see them coming up. Before – nurse leaders before [appointment time was] 8 o'clock, you should come and see me. And if somebody comes otherwise; 'this is not the time I tell you to come and see me, it's not 8 o'clock'. But for me the way I see, no, the nurses come to see me at any time. Because I don't want to pull them away when they come…No, my*

> *nurses…I tell them, when the patients are comfortable, it's OK to come and see me.*

Carspecken (1996) identifies the importance of body language in the interview process. It is imperative for this study to take that concept and adjust and extend it concerning the symbolism of the nursing uniform as an instrument of domination. The nurses in Fiji (apart from the senior nurse leaders) continue to wear starched uniforms and starched white caps, throughout each scorching tropical summer. Edwina saw her nurse's cape as an impediment to interaction with the nurses; in effect as a symbol of power. Yet she also related the discarding of her uniform to her increased levels of responsibility as a leader: 'every day I travel…go to the Ministry…go to the Nursing School. Go everywhere. I can't be wearing that [nurse's uniform] to go everywhere'. In another setting then, discarding the uniform increased her sense of power in the wider system of the Ministry. Carspecken (1996, p. 128) describes "the battle for dignity…in terms of both interactive and cultural modes of power" in his discussion about power and the body, using an example from his own work to illustrate how bodily states assist us to understand how meaning and power interconnect. The nurse's uniform was a clear example of an extension of bodily states to encompass the wearing of particular clothes and the meaning that can have for an actor. Of importance was another event concerning nurses' uniforms in Fiji. There had been some discussion immediately prior to this study about nurses discarding their starched white caps. This was voted upon by the nurses and the proposal defeated by a small majority. At the time of this study, the debate was still part of the discourse of the nursing culture and at the time of writing, the nurses still have their caps.

Again, the notion of what these caps symbolize for those who voted to discard them and those who voted to keep them, remains significant. It may well be that nurses' caps have become representative of the lifeworld of the nurses, given Habermas's (Outhwaite, 1994)

> concept of a lifeworld embodying cultural reproduction (continuity of tradition, coherence and rationality of knowledge), social integration (stabilization of group identities, solidarity) and socialization (transmission of generalized competences for action, harmonization of individual biographies with collective forms of life). (p. 87)

The cap, then, might represent continuing a tradition and providing a feeling of solidarity for the nursing group, in response to the major changes that are being introduced as 'health reform', including the introduction of the clinical governance framework. Tradition and the sense of nursing solidarity would also impact either positively or negatively on the possibilities of improved patient care in Fiji. Nevertheless, what was inferred was that providing increased support for the nurses would enhance the nurses' sense of autonomy, which would then translate to improvements in patient outcomes.

Being patient focused/safe patient care

Clinical governance is concerned with optimum outcomes for the recipients of health care. All of the nurse leaders made continuing reference to their roles concerning good or safe patient care. This may not seem remarkable, given that they are nurses, but the clinical governance literature, as has been shown in this thesis, reveals that an absence of focus on the patient is one of the major impediments to providing decent and safe health care to the community. There is also evidence that nurses who are more satisfied with their work environments provide significantly safer patient care (Rathert & May, 2007). The nurse leaders also suggested this and felt their increased sense of empowerment and being able to fulfill a stronger role as patient advocates, was resulting in better and safer care for the patients. Philomena said:

> *Nursing leaders are really focused on the core business of nursing, the business of nursing in hospitals - patients. That's where we are focusing here. We're looking at safe patient care. You're looking at nurses and doctors actually providing this care for patients at the frontline. As nursing leaders we need to focus on that.*

Reviewing the *point* that the different nurse leaders seemed to be making when they described a desire for improved patient care was important from the wider perspective, the 'system' perspective, of the Fiji Ministry of Health and indeed the nation of the Fiji Islands.

I was obliged to make some comparison between media reports of adverse patient outcomes and problems with health system efficiencies in Australia and in Fiji during the course of this study. The Fiji newspapers, while reporting widely on the nurses' strike of 2005, were less likely to sensationalize adverse patient outcomes or issues such as waiting times for surgery or unavailability of hospital beds as were the

Australian newspapers. The notion of inviting the patient as customer to be involved in health care issues was novel in Fiji, and this was reflected in a lack of media reporting of health service problems from the patient's perspective. This is vital regarding the social constructionism of the patient's place in the health service, which was reflected in the nurse leaders' accounts of a lack of recognition of the patient prior to the introduction of the clinical governance framework. From Philomena: 'clinical governance should actually facilitate the focus we are on – the patient. This is why we need it'; and from Alice: 'the performance of the individual, the performance of the organization, and that should lead to improvement in the quality of care that we give'. Much has been made of the issue of medical domination of patients from a Habermasian perspective, for example, see Barry et al. (2001). Of interest here, however, was a history of a whole *system* domination of patients, which is more accurate than to continue an argument about medical doctors as the single vehicle for domination. The nurse leaders and the medical doctors in Fiji were part of a socially constructed health care system that failed to give 'voice' to patients. Obviously this is not unique and is reflective of an international absence of anything resembling an 'ideal speech situation' where health professionals and health consumers are concerned.

Pragmatic horizon analysis concerning interview text where the nurse leaders described their views about patient care was significant in a number of ways. Firstly, as Carspecken (1996, p.111) indicates, from the perspective of the vertical axis of the horizon, relating to time consciousness, there was a shared perception and interpretation that in the past patients had received less than optimum care at times. However, the nurse leaders also shared an expectation that the future, with the advent of clinical governance, was going to be better:

> *I think one of the best strengths is people are going to be **accountable**, accountable for the services they provide. This is something that has been lacking, people accountable. From the nurse or the doctor. When they provide a service, if they provide a service or they provide information, advice, you must be accountable for what you do, and that, to me, that's the strength. When people are accountable, they do the best, they give the best every day…The risk manager, the risk management…one of the nurses [a nurse manager] asked us…'what is this risk management?' Good, we want to hear people talking about that. We started talking. We gave her a brochure…Because before this, we do it, we don't do it. We just leave it to chance, leave it to the individual. But I think when this is taken on as a*

> *Ministry of Health product or core function, it should come, it should make a lot of difference with the work, the work that we do, for the service. Our special function, providing service, health, to the people of this country* (Bronwyn).

Bronwyn is making a number of important claims here. She is describing a past state of affairs of 'less accountability' ('Before this we do it, we don't do. We just leave it to chance'); a current process of increasing accountability, including through dialogue and education ('We started talking. We gave her a brochure'); and a future intention of more accountability, with a focus on good patient care ('Our special function, providing service, health, to the people of this country'). Of significance here is whether these claims, at this time in Fiji, met "validity conditions to win consensus" (Cook, 2005, p.134). As such, did they make sense for Fiji nursing and the Fiji Ministry of Health? Would they, in effect, 'catch on'?

Certainly the narratives of the nurse leaders in this study indicated that such ideas were 'catching on', and this was reinforced through the provision of resources to give the patients a 'voice'. I recorded the following in my field notes following a visit to one of the major hospitals: 'At the hospital, I met Simione (pseudonym), the customer services officer. He told me of the good work happening "to help our attitudes towards our patients, make them better. I'm training housekeeping staff today". Simione always looks enthusiastic, smiling, keen to talk about his work to improve customer service' (field notes, April, 2006). Customer service officers were new to Fiji and had been appointed in each of the major hospitals as part of the clinical governance initiative. They were an indication of the *sincerity* of the Ministry and the nurse leaders by providing a concrete example of what the nurse leaders were claiming. As Edwina says:

> *You know our core…really, we have been, ah, earlier, in the early days our focus was not on this. For me as a core now, coming to know about clinical governance with patient safety, and that's a core now. And we are focusing on this at the bedside.*

From Coral:

> *I see that, from a nursing point of view, if we put a clinical governance framework in place, it's going to really improve the quality of nursing services, the quality of nursing care. And you would be very much focused on what it's all about. And the role it plays in connection with other health professionals. And that's gonna be very clear. In a nutshell, I would say it's a*

> *real win-win situation.* ***Because the client, the recipient of our care, that is, they'll get the best care.*** *And the people offering the care are very clear in their mind of what's their nature in this, how they can influence this for better improvement, yes.*

Analysis here in relation to interpreting meaning was that the past had been problematic, clinical governance was good and the future would be better. However, an important reminder in this Habermasian reading of the text concerns the notion that "in the staging of communicative action we are confronted with the causal influences of institutional context and history" (Forester, 1993, p. 2). The nurse leaders' avowed intention to provide better patient outcomes also had to be considered in relation to the social system which was the Fiji Ministry of Health and what resisting or maintaining forces were in place (Forester, 1993), to enable or prevent the changes they said they wanted. The nurse leaders referred often to 'core' functions for nursing; this metaphor was significant in terms of their implicit references to what was 'not core'. 'Not core' business for the Fiji Ministry of Health, including the nurses, amounted to those activities which interfered with the provision of good patient care. Implicit claims about what interfered with the nurse leaders' desired role as the facilitators of best patient care were, as has been mentioned, about their perceived history of limited resources and autonomy in the health service.

Personality and best patient outcomes

Importantly, participants also referred to personality factors that helped or hindered them and others to be the best sort of nurses. Carspecken (1996, p. 101) reminds researchers that

> hermeneutic processes do not simply give you an understanding of normative realms common to a different culture; they also differentiate between culturally routine patterns and individually routine patterns…a reconstruction of meaning must be cognizant of the contribution of highly individualized modes of action as well as more shared features.

As has been mentioned, the participants' body language was carefully recorded during each of the interviews and a 'match', between body language and what the participants were saying formed part of analysis. Concerning barriers to good patient care, some of the nurse leaders spoke of people either having or not having personal initiative, noting that those with initiative prospered in nursing and gave better service. There was also an acknowledgement that the nurse leaders could recognize

this initiative in others, with the metaphor 'looking' or 'eyeing' used to describe this: 'as soon as there's a staff nurse going to sister, I eye her' (Edwina); 'when she was at the Nursing School we sort of looked at her' (Bronwyn); 'I'm always conscious that there are people looking at me…all the time I'm certain they are looking at me' (Dorothy); 'All of a sudden they came looking for me…all of a sudden they came looking' (Bronwyn); Coral takes this a little further:

> *nursing internationally has evolved, so a nursing leader in Fiji should be able to **look** outside and see what a major role that nursing in Fiji could take on a par with nursing practice worldwide.*

There is an inference here that communication includes the ability to *look* and *see* what is necessary in a given situation, as well as talking about it.

The nurse leaders reflected upon what had made them successful as nurses; what they wanted from other nurses; how they looked at potential leaders to see who seemed to have the same good characteristics they saw in themselves; and how these characteristics either enabled good patient care (if they were part of the individual's personality), or hindered it (if they were lacking). The end result of this reflection was concerned with, once again, the provision of better and safe care to the community.

Concerning personal success, they said, for example:

> *...I was always trying myself on, trying myself, what do you call it (laughs) trying to avail myself, keep myself abreast and up to date with knowledge. You know, I would read, and at that time we didn't have Internet. Read publications and keep up to date with the current drafts…and try and teach myself…because there are some who just wait for things to be given to them…but I was not like that. I was one who would try and find out things for myself* (Alice); and

> *There's something about, something about my wanting to know more. As soon as I started, even at the Nursing School…there's something about me I could never know [enough]. There's something – anything about drugs I would go and find out more. And I would love telling my peers at School, you know, what I've seen, what I've heard, what I've learned. There was always that edge for me to know more. I would go and research it. Even when I started in the ward as a junior sister, as a novice, any drug literature I would keep it at home. I would go and learn more about the drugs for myself. Any new thing that goes on in the ward. That edge for me to learn more, to know more, and at the same time be confident about that knowledge that I have* (Bronwyn);

> *But I go sit on a computer and I get all my – Internet, I go through Internet. I read, I read a lot* (Edwina)

Philomena relates this 'seeking of knowledge' as a positive attribute concerning personal motivation, noting: 'this person must be motivated…they want to improve themselves'. The introduction of the clinical governance framework supported their personal thirst for knowledge and their ability to not only apply this knowledge themselves, but to encourage others to have similar aspirations. The initial meaning field around these sorts of statements included the notations: 'knowledge is good'; and 'knowledge is powerful'; and 'knowledge equals power'; and 'having knowledge makes me a better nurse'; and 'having knowledge equates to better patient care'. It was important to note at this stage that although the nurse leaders spoke universally about the importance of personally seeking knowledge that would assist them in their professional practice, "not all members of a group are alike in all respects" (Fay, 1996, p.53). Education and the seeking of knowledge was obviously valued in Fiji, but it must be remembered that members of a group may "insist on their distinctiveness in part as a way of resisting the hegemony of more powerful groups" (p.53).

Persuading the nurses

The nurse leaders were aware that all nurses did not share their avowed personal initiative and search for knowledge. Consequently they sometimes engaged in strategic action in order to persuade the nurses to their way of thinking. As Philomena said:

> *Good clinical governance is good patient care. And being a nursing leader* ***I would really like to get into the nurse's mind*** *that we need to be professionally qualified, to be competent. If you are not competent then do something about it, to help us to identify their learning gaps, and providing care for their patients…and that's the thing we need to remind ourselves. We are here for patients.*

Undertaking a pragmatic horizon analysis on this piece of text, which is inclusive of a Habermasian reading about what Philomena was saying, provided rich evidence about what it *meant* to persuade nurses generally that being professionally competent would equate with better patient care in Fiji. Alvesson (1996) contends that

> the management of meaning…is part of everyday leadership…attention is drawn to certain things, and away from others. Language is carefully used. Objects and issues are framed in a particular light, typically reflecting managerial interests and objectives – which sometimes overlap with what may be seen as the interests of broader groups, and sometimes not. This control is

> centred around the ideas and meanings that management wants employees to embrace. (p. 67)

Philomena's contention was that she wanted the nurses to 'embrace' good patient care. The initial meaning field for this piece of text looked like this: 'Good patient care is only sometimes valued here'; and 'all nurses are not professionally competent'; and 'it is the individual nurse's responsibility to become competent'; and 'a nurse can learn to be competent; and 'it is my responsibility to persuade the nurses to become competent'; and 'it is my responsibility to persuade the nurses that they should value good patient care'. I noted in my reflective journal that although this was an interview, "the audience extending beyond the interviewer was in this case…[all the nurses of Fiji]" (Carspecken & Cordeiro, 1995, p.102). As has been noted, Habermas's four pragmatic claims upon listeners (those of truth, legitimacy, trustworthiness and meaningfulness) bear no small resemblance to the paradigmatic axis of Carspecken's pragmatic horizon. Philomena's claim to intelligibility occurred around the idea that both myself as the immediate audience and the nurses as the virtual audience shared linguistic symbols for 'patient' and 'competent nurse'. In terms of legitimacy, Philomena's actions were both communicative (the inference being that if she **could get into the nurse's mind** they would be able to engage in healthy debate about what was needed for good and safe patient care) and strategic (**if I could get into the nurse's mind I would persuade them to my good way of thinking**). Subjectively Philomena implied that she was of good intent for both patients and nurses; her identity claim was one of 'worthy supportive nurse leader for both patients and nurses'. The objective state of affairs was referred to as one where some nurses were not competent and patients did not receive optimum care, but that Philomena was going to participate in changing that. The temporal axis of the horizon indicated the possibility of change in Fiji from a past where it was understood that some nurses provided less than optimum patient care to a future where the possibilities for better care could be created.

Of course Philomena (as did the other nurse leaders) also spoke as a member of the community of nurses in the Fiji Ministry of Health, and as an Indigenous Fijian. The background to her foregrounded statement therefore had to be analyzed both in the wider context of the organization and of her country. Organizationally, the Ministry had committed time and resources to the clinical governance framework, with implied

support for providing optimum patient care. However, as do all organizations, the Ministry had a communicative infrastructure (Alvesson, 1996, p.167) which would serve to both enable and restrict this goal. Although I have written somewhat cautiously about international aid agencies, they do come to developing countries with money and resources, albeit with related power. In Fiji, funding for the introduction of the clinical governance framework and other health reform activities, and the people who arrived with that funding, became part of the infrastructure of the Ministry and were so during the time of this study. Thus, enabling factors in terms of an individual nurse wanting to be competent and seeking the education and experiences to achieve this were inclusive of the effect of these funding arrangements. Enabling factors, then, from a wider system perspective, were partly about the reality of these initiatives being in place, including an improved education system for nurses (Usher et al., 2004). Participants spoke of a changing nursing culture which was contributed to by education: '[Fiji nurses with university degrees] are so outspoken. You know they question things…they are so forthcoming. Forthcoming' (Dorothy). The Ministry, during the time of this study, established a Risk Management Unit at the Head Office in Suva and appointed both Risk Managers and Customer Service Officers in the three major hospitals.

The Risk Management Unit began the first systematic study of adverse events for patients throughout the health system and developed root cause analysis education and experiential support across Fiji (Stewart, 2006). Restrictive factors included a tradition of passivity, as has been explained, but was also about related socialization of young nurses that occurred within the wards and departments of hospitals and community health centres. Coral spoke of middle nurse managers ('it might be the one in charge who sits all the time') role modeling less than patient focused behaviours within the Ministry. Also, patients as informed consumers of health care remained a fresh idea in Fiji during this study, so the possibility of nurse and patient engaging in communicative action about the patient's care was *not* yet part of the culture of the system.

The first 'patient satisfaction' surveys were undertaken during the time of this study and patients *were* coming forward to complain about aspects of the care they received. Consumer driven health care is a relatively new phenomenon internationally. This

involves complexities around responding to consumer needs by providing sufficient resources to meet demand in an economically challenged environment (Stewart, Hanson & Usher, 2006). Nevertheless, this was an important initial step for Fiji and as Dorothy said:

> *I think it's [clinical governance] going to get good results, good outcomes. I mean we had, we had the first, customer…patient satisfaction survey. Oh, that was so revealing. Sometimes we take things for granted. But, yeh, so revealing, and, ah, it's helped the staff to change their attitude. How they speak, and yeh*

While 'attitude' is but one component of focusing on customers, health professionals in Fiji had at least commenced dialogue with the community about aspects of patient care. Work around improving staffing levels, skill-mix of staff, and better conditions for nurses was still needed, but the focus on patients would assist in more awareness of these vital aspects of providing optimum health care. I also noted the following after being present in a meeting to develop an operational plan for clinical governance activities. 'The decision to include a consumer group in the planning process is a new idea here, although the nurse leaders are obviously excited about doing this' (field notes, 2006). The construct of 'patient' was changing in Fiji, albeit slowly, and is better than that of other developing countries, for example, Metwally's (2007, p.5) view of the situation in Egypt when she says "…truthfully, 90% of professionals in the field are not aware that there is something called patients' rights that include intrinsically patient safety".

Obviously, restrictive factors were concerned as well with how much the staff of the Ministry would actually participate in the clinical governance strategies, given a perceived history of less than ideal communication from the Head Office:

> *Sometimes we just tell them "OK, these are the policies and the things that you do". People don't know what are the outcomes [they ask] "why am I doing this?" And that's because of our, ah, you know, the system, where we were only taught* ***what*** *to do. We were never asked, we were never taught* ***why*** *we were doing it. Sometimes our failure to communicate the "whys" can be detrimental as well* (Coral).

The communicative infrastructure of the Head Office would therefore impact upon what in fact happened with clinical governance and certainly with whether a nurse would actually educate herself sufficiently or otherwise. One can begin to see the

background, the horizon, within which Philomena made her foregrounded claim that 'nurses need to be professionally qualified'.

In addition, being from Fiji and in particular an Indigenous Fijian carried significance both for Philomena and for her virtual audience of nurses. The concept of *vakaturaga* (Katz, 1999) is important here. *Vakaturaga* refers to being the best one can be as an indigenous Fijian, essentially "having the characteristics of one who lives according to the way of the chiefs" (p.27). With *vakaturaga*, individual motivation can come from the desire to be of service to other people, in this case a desire to be of best service to patients by having the knowledge to care for them. As the Director of Nursing/Director of Health System Standards for Fiji said upon her retirement: "Girls and boys who are thinking of going into the nursing profession should do so because it is a very noble profession and you can serve people who are not even related to you…but for this job you need a heart of compassion and that commitment because this job will test you…" (Singh, *Fiji Times*, January 22, 2007). Philomena made her claims against all of this background, and the validity of those claims would only be accepted or rejected by nurses in light of the "(re) production of structures, cultural beliefs and identities which form… [the] communicative structure" (Alvesson, 1996, p.171) of the Fiji Ministry of Health. For Dorothy, such changes would come via the nurse managers in the hospitals and community health centres: 'we just emphasize on empowering the sub divisional health sisters, the middle level managers'. Edwina expressed personal responsibility for improving nursing practice: 'as a good leader – all I've got to do is look at my followers'; as did Bronwyn: 'you want to take nursing to a greater height, there's always something that you know you need to do…you have this itch to do better', and Alice: 'I need to have a lot of positive vision for – to be able to take it forward'. Such future focus was consistently about *leading* the improvement of health care delivery to the people of Fiji.

Our role in best patient outcomes

Bronwyn asked herself and me a question during her interview; she said 'how do you know that you are doing the best you can in clinical?', meaning, how can she as a nurse leader focus on clinical care of the patient and be confident that staff are delivering the best possible care. It was not a rhetorical question – she proceeded to answer it for herself throughout the interview and in more informal conversations we

had during my time in Fiji. She, and the other participants, implied that they were best positioned as nurse leaders to facilitate optimum care. They spoke of how this had been hampered in the past due to their inability, contributed to by their less powerful place in the Ministry, to fully participate in debate and decision-making about health policy and practice. The advent of health reform, particularly the clinical governance framework, was perceived as a vehicle through which they could gain greater power, using that power to improve conditions for patients. Dorothy spoke of this power: 'Political, my definition of political is not party politics. Political with power. Because we have the numbers here. We have the nurses. So we get to do things'. Further, in answering her own question, Bronwyn said: 'You have that vision to drive nursing. To improve the organization, to improve the health service'. As Ford (2006, p.47) claims "the front line nurse can still be the patient's best advocate". The nurse leaders saw themselves as the front line nurse's best advocate, and so being, as the patient's best advocate.

Advocacy included the notion of giving clear direction to the nurses:

> *When we are improving health care to the people we ensure that we have competencies in place, so that we are performing well* (Alice); and
>
> *The standards are here…the standards for procedures in assessing, assessing our patient as he gets into the hospital, and then you plan the care, you implement the plan and you evaluate it* (Bronwyn); and
>
> *And the other area that I do have an interest in right now is clinical competencies for the nurses. I have to take it every day – to develop competency level, whether they are able to objectively assess the nurse's performance* (Philomena).

For another participant it was about engaging in dialogue with the clients in a community setting, about educating the population:

> *That's what community health is all about. Selling, selling health to well people. Ah, to people who think that they are well. And we have to be telling them, from the definition of health, that, looking at holistic wellness, that somebody who is not in hospital is not necessarily well. To be well physically, spiritually, socially.*

The Fiji Ministry of Health and Fiji as a nation are obviously part of the wider 'system' in terms of the nurse leaders facilitating a nursing, and indeed whole of health service, focus on good patient outcomes and safe patient care. Obviously,

international strategies that support this work are also significant. The nurse leaders were regular participants in both World Health Organization (WHO) and country agency (for example AusAID and the Japanese government) meetings and conferences about improving health services for the community in Fiji. Aspects of health promotion (World Health Organization, 2006c) and safe hospital care are promoted at these gatherings, which influenced the participants' beliefs about an increased focus on optimum patient care. Utilising Carspecken's (1996) stage 4 and 5 as part of analysis proved important here. The nurse leaders, although acting in part from their own volition in wanting to improve patient care, were also being influenced by changing international perspectives about health care in developing countries. From a broader sociological perspective and considering Habermas's notion of sometimes distorted communication, the nurse leaders became more reflective and skilled in "overcoming these distortions [and working]… toward the organizational possibility of more open questioning, political discourse and the criticism and improvement of policy and action" (Forester, 1993, p.54). The construct of 'patient' as part of this discourse, rather than being somewhat invisible in the whole schema of the health service ('it's all about the staff; what is it about the patient?' - Philomena), began to change.

Whatever strategies the nurse leaders described to legitimize their role as facilitators of best patient outcomes, they were in no doubt that this was their major role. It was also the particular reason that *they* supported the introduction of clinical governance. As Coral reminded me somewhat forcefully during her interview: 'We're not just doing it for nothing. We're doing it for something. These are the real outcomes that we're going to achieve'. The nurse leaders were claiming that they were going to achieve 'real outcomes' for nurses and for patients. With this in mind, I will now turn to their intention, as they recognized their increased capacity for health care leadership, to in fact lead Fiji health care into a better future.

Chapter 6: Recognition of our capacity to take a leading role in health care

Recognizing that they were powerful and that they were empowering the nurses, meant the nurse leaders felt able and indeed intended, to be a force for change in leading health care improvement in Fiji. They exemplified the notion of "the collective value of people who know each other and what they'll do for each other" (Kouzes & Posner, 2002, p.xx). Elements of their lifeworld included a situation in Fiji where enormous influence had been and continued to be exerted by traditional leaders (Nayacakalou, 1975). Their intention as nurses and women to enhance their capacity to take a leading role in health care was a move away from a traditional male medical dominated system. This thesis, therefore, describes a process whereby they were moving towards liberation from such limitations. They had become increasingly reflective both before and during this study and were living in the sort of circumstances described by Alvesson and Willmott (1992) where

> emancipation describes the process through which individuals and groups become freed from repressive social and ideological conditions, in particular those that place socially unnecessary restrictions upon the development and articulation of human consciousness. (p.432)

They spoke of their vision for an effective health service where they, as the nurse leaders, were the 'drivers' of change and a 'bridge' to the future. A consistent theme throughout the interview texts and in more informal conversations, was one of a new recognition of themselves as people who would take Fiji forward to the prospect of improved health care. This did not come without cost, however.

Redefining our sense of belonging to the nursing 'group'

Health reform in Fiji, including introducing clinical governance, changed the way in which nurses saw themselves as a profession quite separate from that of medical doctors. This initially brought a sense of loss to some of the nurse leaders who had valued the solidarity of the nursing group. In 2003 the Director of Nursing was given the additional portfolio of Director of Health System Standards. For Dorothy, this meant having to share the Director of Nursing with other health professionals and losing a sense of ownership she had for the 'top nurse':

> *…the challenges that come with change. At first we though we were going to, that we were going to lose our Director Nursing. I know, for a senior nurse in the field, to hear that we were going to lose our top nurse. That was, that was a blow. And I started to think: ' now, who is going to be ah, who is going to*

be our leader. Who is going to be the chief nurse?' That was hard, that was hard to swallow.

Edwina had a different concern when she spoke of her commitment to the nursing group: 'It's very important**.** It's important for sustainability and a sense of belonging'. She voiced her concerns about nurses moving into risk management positions, which she saw as a loss to the nursing profession.

But the problem, Lee, one thing that I am really cautious about in pulling away nurses and then the career path for her is not there. It's like OK [there is] a Sister now who takes up risk management…they'll lose their career path in nursing.

This idea of a sense of belonging, or solidarity, as has been mentioned, is crucial in terms of the lifeworld of a group. The redefinition of 'group of nurses' to 'group of health professionals' was implicit in much of what the participants said about the struggle involved in becoming part of the latter group. With this change, though, they also said they could then go on to be leaders of all health professionals towards the provision of better health care. Philomena talked about her commitment to the nursing group, saying: 'I have the heart for nursing. I have the heart for nursing', but she also said: 'I have a lot of people who come to me, they're reluctant to change, their acceptance of change. So what we are doing now, we are taking it to another level…we are still here and we're leading them through this'. The 'we' she referred to was the multidisciplinary group of leaders in her Division.

Bronwyn was also very much focused on the multidisciplinary nature of health care:

The leadership. I think it ought to be multidisciplinary…I'm talking about the health services in general, eh. I don't think nursing can ever be on its own, no, it can never be on its own. Wherever you come from, at all levels, from operational to management…because you know health is so multidisciplinary. It can never be, you know, what the nurses are doing, what the doctors are doing, what environmental health is doing in Fiji.

She also voiced her support for nurse leaders: 'I feel that with your nursing, your nursing experience, you can lead, if your leadership is good, you can lead anyone….as long as they know what you say, they follow you'. The tension between wanting to be multidisciplinary and having to adjust their sense of belonging to the nursing group was significant. The participants linked becoming multidisciplinary with their ability to provide better patient care, they wanted to provide better care. However, in achieving this, they were losing an element of their lifeworld that had sustained them

through difficulties over many years, that of being part of a recognized group who cared for and looked out for each other. Their challenge over the ensuing years would be to redefine their sense of 'lifeworld'. In order to do this, they had to redefine their sense of what constituted their 'group'. This is never an easy task and provides an excellent illustration of Habermas's (Outhwaite, 1994) impression of what can go wrong when the lifeworld is colonized by system. The challenge for the nurse leaders and indeed the nursing profession, was about avoiding the loss of meaning and absence of social solidarity possible when such changes occur. In striving for an increased say in what happened to patient care in Fiji, that is, moving closer to communicative action with all health professionals *and* with the patients, the nurse leaders needed to remain reflective about what such emancipation could mean to both enable and disrupt their profession.

As Dorothy said when outlining the changed role of the Director of Nursing: 'I suppose I see her, with her extra work she has to do as Director for Health System Standards. I have to understand. I have to appreciate that. And, and I value the times she has come and visited us'. The Director of Nursing was, in effect, enabling the nursing profession by maintaining links with her subordinates in this way, at the same time as others saw clinical governance as potentially disruptive. One participant spoke of the movement of nurses into non-nursing positions, in order to support health reform. 'I lose them from the normal…from the normal nursing. And at the same time I feel for them because there's no career path for them. And there's no reward system like extra pay for them'. Her opinion was that nurses were the best people for these positions, but that the positions should be incorporated into the nursing career structure, which had not happened at the time. This notion of maintaining the solidarity of nursing was perceived as important, despite the move to a multidisciplinary focus on the patient rather than on the different health professions. As will be discussed, other professionals in the Ministry also resisted the changes.

'Raised eyebrows'

As such, the nurse leaders were not alone in their struggle with a new empowered role for nurses. It was only recently that nurse leaders were appointed to senior generic management positions within the Fiji Ministry of Health. They referred to the responses of both nurses and doctors to this event:

> *It's only [now] to see nurses holding positions, where it used to be for doctors only. That's, that's a milestone. And I believe nurses can do the job well, seemingly as well as the doctors...look at the North. We have our nurses who are in General Manager's positions…it's always been a doctor, or an executive officer…I'm aware there have been some raised eyelids, and some eyebrows…I remember this meeting when we were looking at the subdivisional [management position]. Whether we had to open up the subdivisional post for the doctor. And the nurses said: 'no, keep it open so anyone can participate'. We received a lot of resistance, remarks such as, from the doctors: 'well, if the nurse has to be the subdivisional medical officer than she has to be good'. Yeh, yeh, that's coming from a doctor. So, I'm sure this is seen as a threat, too, in terms of administrative skills, I believe we can do better. Yeh* (Dorothy).

Analysis on this segment of text provided some clue as to the place of the nurse leaders in the hierarchy of the Fiji Ministry of Health during the time of this study. They saw themselves as equal to, or sometimes better than, other professions in their leadership role. They indicated that this was threatening to some of the medical doctors and it was implied that they had to be better than the doctors in order to prove themselves ('she has to be good'). Here, Dorothy was asserting that it was new for a nurse to be in such a leadership position ('that's a milestone'); she made two different claims about the competence of the nurse to undertake this role ('nurses can do the job seemingly as well as the doctors' and 'I believe we can do better'); she said that the doctors did not want the nurses in the positions, but that the nurses had persuaded them otherwise ('we received a lot of resistance remarks such as from the doctors, and the nurses said "no, keep it open so anyone can participate"').

The validity of these claims can be compared with other events that occurred in the Ministry of Health at the time. The Director of Nursing/Director of Health System Standards carried out a leadership position that encompassed leadership across the professions. For example, she carried leadership responsibility for Pharmacy Services and Oncology Services, chairing cross-disciplinary meetings for these services and coordinating health reform arrangements (the reality was that a nurse was involved in multidisciplinary leadership). Other nurse leaders who became General Managers for periods of time ultimately were removed from those positions and replaced by either medical or administrative personnel (this was a new cultural phenomenon and one which had not 'caught on' in the Ministry during the time of the study, possibly because the nurse leaders were seen as a threat to the status quo). One of the

participants indicated that this removal of nurses from the General Manager positions they briefly held was due to both medical and general administrative staff resistance to nurses holding such posts: 'And I'm aware too that that post has been rescinded…I'm also aware that the General Manager Corporate where a nurse was has now been given over to the administrative staff'. Fiji is no different from the international health community; in that the traditional place of nurses in terms of "the structural elements of the healthcare situation" (Street, 1992, p.9) has been one of subordination. The nurse leaders of Fiji were challenging this structure and the system was fighting back. As Street (1992) reminds us, change like this does not come quickly:

> nonviolent emancipatory change takes a commitment to ideology critique and negotiated collaborative strategies for change and takes time. (p. 23)

The nurse leaders recognized their changing roles as evolutionary. Although disappointed when positions such as those of the General Managers were given to nursing and then taken away, they did not see this as the end of their emancipatory efforts. Rather, they were preparing for a future where they would take a primary leadership role:

> *And from tomorrow and from next years it's only going to be more dynamic in nursing. Nursing for the future has got to think outside the box* (Philomena) and

> *The change is inevitable. Because it's not only nursing that is changing. The whole world is changing, the whole processes, the whole mechanisms are changing. So nursing has to put on their boots…so a nursing leader in Fiji should be able to look outside and see what major role that nursing in Fiji could take to be on a par with nursing practice worldwide* (Coral)

Coral employed the metaphor 'put on their boots'; Philomena spoke of thinking 'outside the box'. They used metaphor to describe a world that they saw was going to be different from the one they had been occupying. It has been noted that the use of metaphorical language can sometimes better describe the range of emotions and experiences of human life than literal language (Palmer & Dunford, 1996; Srivastva & Barrett, 1988). This seemed to occur with participants' use of metaphor. Inherent in all of this was the notion that somehow, international efforts in health care were superior to those of Fiji.

Nursing leadership worldwide

I have previously alluded to the participants adopting elements of Western culture and practice they saw as beneficial for themselves and Fiji. They did this as part of their intention to take an increased leadership role in Fiji healthcare. All referred to their impression that nurse leaders from countries like Australia were generally well-educated and assertive and they wanted nurse leaders in Fiji to have the same assertion and negotiation skills as their Western colleagues. For example, they said 'You need to negotiate and I would like nursing leaders to have this knowledge' (Philomena) and 'You talk with some assertiveness' (Bronywn).

Again, Philomena relates achieving this aim to *educational* preparation for leadership:

> *It has made a lot of difference. It has, somehow, assisted me to be able to vote for this Reform, this change. This Reform, in the Divisional structure, in the change. It has really made a difference, personally, to me, in how I conduct my work and organize my work. As well as creating an impact, in being more visible in providing leadership. I think it came at an optimal time [leadership education]…It's main purpose was to prepare nursing leaders in the South Pacific. To enable them to provide direction in leadership in nursing. In this time of change, this Reform. For me, personally, it's…it's made the difference. In looking back it would have been very difficult for me if I had not been prepared well. This education program, development program in leadership. If I hadn't gone through, I would have been really frustrated about it. I wouldn't have lasted. I would probably have gone. I persevere today simply because I need to contribute towards nursing in Fiji, because I've been given the opportunity.*

Dorothy made similar links when she said: 'I think the nursing leaders overseas are very highly qualified…the knowledge and all the opportunities they've been exposed to'. Edwina described what she wants for the future:

> *For me, leadership now – if you go for another five years or ten years, I would be just exactly like you in Australia or New Zealand. It's like, I get things done here…For Australia and New Zealand, for most leaders you are so advanced and I want to be like you. I want to be like you.*

They equated positive attributes of Australians or New Zealanders or themselves as 'being driven', or 'being visionary'. Philomena, when describing her belief that the nursing profession would facilitate the outcomes of the clinical governance agenda, said: 'You need to have a driver, you need to have somebody to drive', indicating that nursing would do this. From Dorothy: 'I like the assertiveness in the nursing leaders overseas'. In admiring assertiveness and wanting to be increasingly assertive themselves, the participants indicated an intention to fully participate in decision-

making about health care in Fiji. This is vital, given that "the underlying notion in Habermas's project is that people are – or given favorable circumstances may become – the supreme judges of their own best interests, which are formed and discovered in free dialogue between all those involved" (Alvesson, 1996, p. 139). To engage in 'free dialogue' is to have both the confidence and the structure to be able to do so. Constructing meaning fields around statements such as: 'I want to be like you' (an Australian) and 'I like the assertiveness in the nursing leaders overseas' led me to the probability of a desire on the part of participants and in this case a move towards, being the sort of people who were able to participate equally with others concerning aspects of professional life and health care decision-making. The metaphor 'driver', however, also indicated a desire to be in control of this process rather than merely an equal participant.

This can be problematized in relation to the research process itself. How was the reality of participating in the study affecting the nurse leaders' perception of their roles? Alvesson and Skoldberg (2000, p. 129) remind researchers that "it is worth remembering that the mere interest in the phenomenon of leadership may mean strengthening and legitimizing asymmetrical social relations". Obviously, critical research such as this was political and was going to have consequences for the nurse leaders. While speaking often of 'equality' they also indicated a wish to be more powerful than others at times. Street (1992) discussed the possibility of nurse leaders practicing 'horizontal violence' within nursing, and the chance of newly empowered nurse leaders practicing violence outside nursing, against former perceived oppressors, also remained important. This was implied but not observed during the study; however, in terms of an intention within the research process to enhance communicative action inside the Fiji Ministry of Health, it had to remain part of the reflexive process.

Being an effective leader

There was much discussion with the nurse leaders about what made a nurse an effective leader. They made a strong correlation between leadership effectiveness and good patient outcomes. As has been mentioned, they saw these positive traits in 'overseas' nurse leaders, but many also saw them within their own group. High on

their list was the ability to be forward-looking, to be able to anticipate and plan for the future. They said:

> *You want to foresee the future, to be able to anticipate - who is able to identify trends, to look at today in order to envisage what will happen in the future* (Philomena) and
>
> *I need to have a lot of vision…to be able to take it [clinical governance] forward* (Alice) and
>
> *You must learn – what is there, what do you want to see in the next five years. That is something you always do. You know you try and simulate the [future] environment, simulate, rather than just being content with the routine, the day to day* (Bronwyn) and
>
> *[You] can't have a nurse leader dwelling on the past all the time. I need the next leader to focus on the change that's coming* (Edwina).

The introduction of the clinical governance framework, as well as other aspects of health reform, was viewed as the conduit to assist many of them to harness this ability to be increasingly reflective and future-focused. Fiji in the future was also a place where the next generation of nurse leaders would take on the attributes that the participants had developed, because the participants, many of them at the latter stage of their careers, would choose and mentor good people who would 'put on their boots' (Coral). These metaphors about taking action; being driven; putting on boots; and focusing on the future were used often by participants during the course of the interviews, and otherwise. There was an implied comparison with a past where nurses were subjugated and less able to take action to drive health care and what was beginning to happen. They were extremely focused on the prospect of the contribution they were making for the next generation. There was a strong link between this notion of contribution and the idea of leaving a positive legacy. Being a nurse leader who was part of introducing clinical governance was:

> *wonderful, it's wonderful. I'm really excited that I can share it with the young nurses, and with my children and grandchildren, that I've been part of all this change that is happening in Health in Fiji* (Dorothy) and
>
> *And I just feel good, you know, at the end of it, towards the end of my career, that I'm able to contribute* (Alice).

Describing the characteristics of those she wanted as the next generation of nursing leaders, Philomena said they needed 'a focus on what they would like to pursue. Especially in education and development. They need to have some **dreams**'. She

said they must be able to challenge the status quo and repeatedly said that they must be able to think critically about what was happening. She compared the idea of 'dreaming' with thinking and with setting goals for the future. This whole notion of *reflective* nurse leaders was vital for the participants; they linked good critical thinking and reflection with the ability to take appropriate action to improve health care. As Bronwyn pointed out: nursing leadership is 'challenging, and always, no complacency, there's no time for complacency'. The implication was that nurse leaders needed to be resilient; the participants noted that good leaders could take criticism and keep going, rather than giving in to self-doubt. For example, Philomena linked good leadership to the acceptance of criticism:

> *Because leadership is…you're so visible…and this person should be able to know, this is our leader, a person who can accept criticism*, and from Edwina

> *I want them to be more assertive. I want them to tell me 'you are wrong', when I have said something. I'm not, I'm not a nursing leader that – I want to be criticized. I want them to debate [me].*

Another participant talked about her personal struggle as a nurse leader when she made a mistake, explaining how she responded and indicating that others should do the same:

> *And it was a big issue as if I had committed the biggest crime. And I knew it was coming very personally. It's the personalization of things that bugs me a lot. So I couldn't, um, but I tried all my best to look at things positively. And I tried to understand that they have their own reasons for the way they reacted. So what I did was, I know very well it's not going to help if I react. But I sort of made sure that I only respond. Let them do it. They were my nursing leaders. There was no way I was going to pick a bone. So that's exactly what I did. Play by ear, just do the work, deliver the goods, and finally they came round. And just recognize your strengths.*

This participant is clearly identifying that domination does not simply come from outside the nursing profession. Nurses are every bit as capable of participating in their own oppression (Street, 1992) as is anybody else. To a greater or lesser extent, the participants recognized this and made efforts to be different. The participants' identity claims were important here. Carspecken and Cordeiro (1995) note that it is

> because the desire to maintain a positive identity requires intersubjective agreements employed to earn the positive regard of others, the cultural milieu through which actors claim and maintain identities will reflect broad social relations and the economic and political inequalities of those relations. (p. 88)

The participants made their claims about what it took to be an effective nurse leader to me, as their immediate audience, but we all understood that the information (although de-identified) would become part of the public domain in Fiji. This would be through the publication of journal articles, conference presentations and the presentation of this thesis to the Fiji Ministry of Health. So there was a wide virtual or future audience to whom they were telling their story about the sort of leaders they were becoming, and what they were doing to ensure the same sort of nurse leaders took Fiji into the future. Their claims reflected the reality of the nursing profession being traditionally less powerful in the Fiji Ministry of Health. They also reflected a time of change, with the introduction of clinical governance, where inequalities were less than they had been. Of course, methodologically, it was imperative to continue to compare the interview material with actual observations of activities (Carspecken & Cordeiro, 1995).

Field notes I recorded were inclusive of meetings at which I was present, chaired by some of the nurse leaders, or workshops where they were the facilitators. In attendance at most of these were nurses, doctors, dentists and administrative personnel. One field note entry excerpt read as follows:

> Nurse leader chairing meeting, set agenda, thanked others for coming. Prayer and food to commence the meeting. People present include doctors, nurses, administrative people. Lots of conversation about the Tsunami warning in Fiji this morning, I didn't know about it until I got here! Everybody speaking while eating, but meeting changed quickly once nurse leader began to chair. She's leading the meeting very strongly…she left at one stage to attend another meeting briefly, and everything immediately became more informal. Group tended to speak more freely. When she returned, the conversation continued more freely briefly, then became more formal as she 'took the reigns' again. Energetic meeting, lots of conversation, goals, outcomes. (Field notes, May, 2006)

This entry was indicative of many others made during my time in Fiji. The participants in the study were taking an active leadership role; they were future focused; they were assertive; other health professionals were listening to them; they were taking plenty of action; they had 'their boots on'. The match between what they were telling me and what I experienced was quite consistent and indicated sincerity around the sorts of claims they were making during interviews. Of course, the machinations of the Fiji Ministry of Health proceeded largely without my presence and I am only able to comment on what I was told and what I saw and heard in the

field. As Alvesson and Skoldberg (2000, p. 134) point out "only limited aspects of a phenomenon lend themselves to being illuminated in a particular study". Nevertheless as exemplars of 'what was going on', these occasions were important events in developing an understanding about the place of nurse leaders in Fiji at the time. If "action shapes meaning" (Forester, 1993, p.25), then the apparent respect accorded the nurse leader in the meeting just described was indicative of the increasingly powerful role participants had as nurses leading the way in health care policy and practice.

A bridge to the future

The nurse leaders saw themselves as the key to the future of better health care in Fiji. They respectfully acknowledged the work of their medical colleagues, of allied health personnel such as dentists and of the lay administrators in the Ministry of Health. However, they saw themselves as having an equal, if not superior, role in improving patient care through good clinical governance.

> *Nurses who can mobilize the workforce, take it to another level, they [pause] can [pause] do…they can be a bridge. And my heart tells me we need to do the work to be a bridge* (Philomena) and

> *It's important that nursing leaders have some ownership of clinical governance. They need to have some ownership and they've got to, you know, it's something they have to appreciate and understand that it's going to be an integral part of their role. To not only oversee the implementation processes, but also be accountable that it's achieving its goals. So, as matter of fact, that's why we need strong leadership in nursing, you know. People that can be able to teach it, monitor it, assess it, evaluate it, and use that for future planning. Yes, I think that for nursing leadership, there's no two-way about it. And because it's clinical governance, the nursing leaders have got to buy in. And not only buy-in; they have to take that as an integral part of their role as nursing supervisor* (Coral).

Bronwyn equated the ability of nurse leaders to be a 'bridge', to provide a leadership role to all health professionals, with the way in which the nurses presented themselves:

> *And with this, at the same time, when you talk to them, you talk with some assertiveness. Yeh, assertion. That, to me, is one thing, one of your trump cards you know. You talk, you know, you have the facts, you have the evidence, it's not something that's just out of the blue, and I find it's very helpful…So I think it's how you carry yourself, you know, as a person.*

Ideas about effective leadership abound (Kouzes & Posner, 2002) and from a wider system perspective, the nurses in this study were speaking at times of great change and often political turmoil in Fiji. The local newspapers and television news programs constantly regaled those of us who were in Fiji during those years with opinions about what good leadership meant for Fiji. Often related to impending government elections or threatened coups, these media reports provided an indication of what the nurse leaders were exposed to concerning local opinion about leadership. For example, Bishop Apimeleki Qiliho, an Anglican Church Bishop, wrote that leadership in Fiji

> is about envisioning the future on the basis of the present. Despite the adverse events in our recent history, there is still abundance of goodwill and a high degree of resilience among our people. These are the basis that our leaders can build a more sustainable and durable nation for the future. (*The Fiji Times,* Saturday, May 6, 2006, p.7)

I have previously discussed the significance of the Christian churches for the Indigenous Fijian participants in this study. The clergy featured prominently in the local newspapers, invariably making political comment. Pragmatic horizon analysis around the sorts of things the participants were saying or implying about being the 'bridge' to build a more sustainable and durable health system, with a focus on good patient outcomes and safe patient care, was particularly revealing. Being good people, being good nurses and being good nurse leaders meant being good Christians. Good Christians presumably take some note of what the clergy are saying about the way the world should be. Good reflective Christians, as the nurse leaders were proving themselves to be, are possibly bridges across stormy seas. The meaning field constructed for Philomena's statement: 'And my heart tells me we need to do the work to be a bridge' included Christian references, as did other meaning fields.

The Bible tells the story of Jesus Christ walking on a stormy sea and calming it (Matthew 14:22-33 ESV). Fiji between the years 2004 and 2007, which encompasses the time of this study, was a 'stormy' place, with a coup in December of 2006 and reports of the economy being 'close to collapse' (Marris, *The Weekend Australian,* March 3-4, 2007, p.2) in March of 2007. The nurse leaders lived with the threat of such eventualities throughout the period of this research and the horizon within which they made their claims was inclusive of this environment. At the same time, their

perception of their roles as successful and effective nurses and women was subject to continued criticism:

> Women are …becoming more competitive in the workplace. With this, they are rightly calling for equal opportunities, equal pay and privileges. No doubt many are ambitious and no longer want to be stereotyped as housewives who belong only in a kitchen. In Fiji, women play an important role in economic and social development. As nurses and doctors, they are the driving force in the health service…*but some women are so engrossed in their new-found power, for want of a better word, that they have neglected their roles as mothers in the family* (italics added)…the traditional role of women in the family cannot be absolutely ignored because of changing lifestyles or because they are now better educated…*fortunately some women including professionals such as doctors and teachers have not forgotten or ignored that important role* (italics added). (Editorial, *Fiji Times*, March 8, 2007)

The ready implication here is that nurses are women who are misusing their power and neglecting their Christian duty as mothers and homemakers. Again, this is the horizon within which nurse leaders continued to make their courageous claims that they were going to be the bridge to a better health service in Fiji. With this, they made tacit and overt claims concerning the need for courage, perseverance and determination: ('I persevere today' (Philomena); and 'Ah, how I've come up here in life is the determination you have in yourself' (Bronwyn); and 'so nursing has got to put on their boots' (Coral). This happened against a background of both the structural system of the Ministry and of Fiji (for example 'women are so engrossed in their new-found power') that continued to impact upon their determination to be the best sort of nurse leaders and the bridge to a better future.

Overcoming our barriers to having a leading role

Habermas's notion of validity claims, as has been mentioned, constitutes criteria for determining how reasonable competing claims actually are. The participants, and myself as researcher, engaged in a communicative process where I eventually arrived at a thesis that the nurse leaders generally saw clinical governance as an emancipatory tool for themselves, for the nursing profession and for their patients. They also made claims that problematized how this was going to happen, describing barriers that needed to be overcome in order that their use of clinical governance could fulfill the aims they had for optimum patient care. Barriers referred to were inclusive of their role as employees of the bureaucracy which constituted the Public Service in Fiji; a traditional system of promoting people into nursing leadership positions, eventually

resulting in most of them being compelled to retire from the Public Service at the legally required age of 60, so that the current group of nurse leaders were retiring together; the migration of skilled nurses and therefore potential nurse leaders, out of Fiji; and less than optimal implementation of the clinical governance framework in Fiji.

The Public Service and retirement

Strategic communication is a feature of modern organizations (Alvesson & Deetz, 2000). Nevertheless, the Public Service in Fiji had goals that were consistent with managing a workforce in the most effective way, in a country without the resources enjoyed in more 'developed' nations. All of the participants in this study were Public Servants and as Alice said: 'You know, we belong to the Public Service, the government. We belong to the Public Service Commission'. The implications of 'belonging' to a government department are possibly those of not being an autonomous practitioner. The meaning field around this statement included the following: 'Belonging means having no control' and 'belonging means we do what the Commission says' or 'belonging gives us a sense of solidarity' or 'belonging gives us a sense of status in the community'. Alice's body language when making this statement was recorded as: 'very matter-of-fact. She shrugged when she said this, inferring – that's just the way things are here' (Field notes, 2005). Alvesson and Willmott (1992, p.433) provide some insight into the possibilities for critical theory and emancipation in a bureaucratic organization; they say "For CT, emancipation is not a gift bestowed upon employees; rather it necessitates the (often painful) resistance to, and overcoming of, socially unnecessary restrictions". Belonging to the Public Service for nurse leaders meant that they could be 'posted' or transferred to any health care facility throughout Fiji. They were expected to often leave friends and family in one locality and go to work in another.

Additionally, the retirement age for nurses was sixty years, and despite some older nurses being re-employed after that because of particular skills, all nurses were obliged to finish their working lives at sixty. This posed particular challenges at the time of this study. Many of the nurse leaders reached this age within a few months of each other and participants noted concern about who was to replace them. Bronwyn said, for example: 'My only wish is that there are more, more nurses who can lead,

really lead. Leading and operational, they're two different things'. Whether retirement at sixty was 'socially unnecessary' or otherwise in Fiji was contentious, but the concern from the nurse leaders was that of loss of knowledge and skill from the profession, particularly in relation to being able to pursue the clinical governance agenda. Of course implementation of the framework itself was also not without challenges.

The problem of implementation

The nurse leaders indicated that as the key facilitators of the implementation of clinical governance in the future, they would avoid the problems they had seen with the initial implementation. Some of these have previously been alluded to, including the tendency for Head Office to fail to include front-line workers in the early stages of planning. For Bronwyn, there would be recognition that when a new system was introduced 'it just opened up a Pandora'. When questioned further about this she said that commencing any reform revealed many other deficits in the system which then needed attention. Coral noted that involving staff at all levels was the key to success:

> *One of the things that most of us as health workers and I hate to say that, I keep using the word culture, um, when you want to introduce new things, it's always, you know, sometimes it does meet a lot of resistance. And that resistance could be because people aren't aware on the very, the very, when it's just getting off started. And all of a sudden they think – ah, to have their input midway. Sometimes it's because people are not informed in the planning period, and they don't have the ownership of it, so they don't see the necessity of it all. And sometimes it's just plain ignorance, and people see new things and new concepts as another burden, additional things to their responsibility. And people don't buy into it. But when they could grasp things, the very nature of things and how it's going to improve the services, and perhaps their delivery of those services, people do, do buy into it…if you get their involvement at the very early stage, at the very embryonic stage of things, you'll get the buy-in later. So we can be developing things at this level and building castles in the air'.*

Analysis of this piece of text was significant in terms of the sort of hierarchical system that had been in place in the Fiji Ministry of Health.

In describing 'culture', Coral was referring in part to the lifeworld of Fiji, where the front-line workers had an expectation that their colleagues in Head Office would talk to them about any changes to be introduced, and that their relationships with each other were such that praying together, eating together and talking together was the

'way things were done in Fiji'. I saw numerous examples of this sort of behaviour, where, outside formal meetings, understandings and relationships were played out in everyday, take-for-granted ways. 'Getting buy-in at an early stage' meant talking with people and telling them what was going on. Hierarchical system arrangements and secrecy interfered with this, as it tends to in bureaucracies and Coral was claiming that this then prevented the best outcomes in terms of making good changes in health care policy and practices. Her inference was that she would not do this and it was a challenge to check the sincerity of this claim, although I did observe examples of nurse leaders withholding information (as I had frequently done as a nurse leader in Australia). Reconstructing meaning for this piece of text involved considering possible meaning fields initially. These included 'I am a nurse leader but I'm just one of the health workers – Head Office does not tell me things either'; and 'Head Office should keep us informed'; and 'Head Office should inform us in the early stages of a project'; and 'If people are told early about changes, they will often actively participate'; and 'Castles in the air have no foundations, so the changes will not last if the workers do not participate'.

Carspecken's (1996) reference to 'the objective state of affairs that exists' was important here. In the foreground was a claim that if front-line workers were not involved early, they would not fully participate in health reform. In the background was a situation where staff might overtly agree to imposed changes, but that they could in fact quietly sabotage those changes by less than optimum participation. I also observed, rather than the deliberate withholding of information, situations for busy nurse leaders who simply did not 'get round' to talking to staff in the way they claimed they wanted to. Strategic rather than communicative action tends to be a feature of organizational life and the nurse leaders' implicit claim was that their communication would be better than that. The systematically distorted communication that Coral is referring to has been described as that where

> the dominating elements are assymetrical social relations, mystification, insincerity, manipulation, rhetoric, distorted descriptions and disinformation.
> (Alvesson & Skoldberg, 2000, p. 120)

The nurse leaders, as has been mentioned, claimed they had a new 'open door' policy and I certainly saw that. Nevertheless, in organizational life some 'horse-trading' is going to happen. The intention of the nurse leaders to engage in healthy dialogue with

everybody involved in the health system was indicative of their *awareness* that the absence of providing staff with information was a problem. Such awareness, or reflection, is the beginning of praxis. This is consistent with Alvesson's (1996, p.24)) contention that "the purpose [of liberation] is to open up thinking rather than to suggest a specific route to take or a particular solution to embrace". The next step for the nurse leaders, which *was* happening, was to not only reflect, but also to take action to change the situation for their subordinates.

Workforce planning – the migration of potential nurse leaders

The migration of nurses out of Fiji, as has been mentioned, was a continuing problem for the country. For the participants, migration meant the loss of not only the nursing workforce, but also of potential nurse leaders who could take health care forward in Fiji. One participant described the situation:

> *And one of my biggest challenges here, Lee, is losing my skilled nurses. And trying to maintain the standard, with my young nurses and the very old nurses. And all the skilled ones, the middle ones, I'm losing them. That's quite a challenge for me to keep things going [they go to] England, a lot of them go to England, a lot of them to Australia, they are going to the Marshalls. But the latest trend now, they are going to the United Emirates, the current strand now. There are a lot of people now being taken there, they are waiting to go. The latest trend now is Dubai…I want to believe they won't go, that there'll come a time that they won't go, they'll come back. But one thing I'm always thankful for here that they go like those that go to Marshall Islands for two years. And then "I don't want to stay there, there's no place like home. I want to come back home"…Back home, from the Marshalls [they bring money] to buy their houses, buy their car, they come back. It's like, there should be something like soldiers, for nurses. They go to Australia, they sign up for two or three years, and they should come back…because when they go to Australia, so, the skills improve, and I have them back. And I always welcome them back. I'm somebody that – "Oh, you're back, come back, have you?" I encourage them when I see them…But some of these places I lose them and I lose them forever…Australia, they like Australia somehow. They will not come back.*

It is imperative to consider the sorts of claims the participant was making here from the perspective of system colonizing lifeworld. Without a viable nursing workforce, the hopes of good patient care in Fiji were not going to be fulfilled. Analysis of some of the reasons why Fiji's nurses were leaving were apparent, given the better pay and working conditions that awaited them in developed countries with nursing shortages. Indo-Fijian nurses were also leaving because of the political unrest and ethnic

tensions in Fiji. However, it was apparent that the developed world ('a lot of them go to England, a lot of them go to Australia) was once again collusive in luring nurses out of Fiji ('there are a lot of people now being taken there'). Actors will act of their own volition, but the seduction of Western influences ('buy their houses, buy their car') was also draining the country of a vital workforce. The participant was making a normative claim that the most skilled nurses were leaving Fiji for better pay and working conditions and many of them did not return. She was addressing a virtual audience of Fiji's nurses, but more importantly, the Fijian Government and Governments of those wealthier countries who are the beneficiaries of Fiji's skilled nurses.

An implied claim concerns the ethical responsibilities of those who leave and those who seduce and accept them. The migration of nurses from developing to developed countries has been scrutinized (World Health Organization, 2006b) and should remain the subject of ethical discourse with reference to Habermasian ideas about the ideal speech situation. At the macro level of society, the question of whether it is socially acceptable and/or responsible for rich societies to poach skilled people from poor ones must be considered. The internationalization and globalization of health care is obviously mutually beneficial. As has been mentioned, international aid agencies bring money and resources to countries like Fiji. Do their governments, however, take more than they give? This contentious issue, when considered in terms of the ideal speech situation, or of lifeworld being colonized by system, might be clearer if, for example, one imagined a conversation between the participant and a nurse leader in Australia. Assume that both are attempting to work within a clinical governance framework and that both have an aim of providing best patient care for their communities. Both need skilled nurses to achieve this. However, the nurse leader from Australia and the nurse leader from Fiji are not the beneficiaries of equal amounts of resources with which to persuade nurses to work for them. It is not a level playing field. The participant's comment is significant here: 'It's like, there should be something like soldiers, for nurses. They go to Australia, they sign up for two or three years, and they should come back'. Jong-wook (World Health Organization, 2006b, p.3) urged governments to develop "international cooperation to align resources, harness knowledge and build robust health systems for treating and preventing disease and promoting population health". Effective implementation of clinical governance

in Fiji, as the participants indicated, was going to take this sort of cooperation, rather than the continued emigration of skilled health professionals from Fiji. The situation requires the healthy debate of communicative action to enable nurse leaders internationally to create a structure which would be beneficial to more of the world, rather than to those countries with the most wealth. For the participants, being able to engage in debate about these sorts of issues would contribute to their ability to take a leading role in health care in Fiji.

Taking the lead with clinical governance

Considering Carspecken's (1996) stages 4 and 5 here, the nurse leaders were making claims that they could take an important lead in implementing clinical governance. Their focus on improved education for nurses, effective risk management and an enhanced focus on the customer (patient), was clear. Importantly, their personal and professional lives were played out against a communicative tapestry of the social system which was the Fiji Ministry of Health from the years 2004 to 2007. If society comprises systems relations (Carspecken, 1996) then the Fiji Ministry of Health was continuing to develop and change as a multitude of interactions occurred among all the people who were involved with the Ministry, including myself as both consultant and researcher. The conditions that would either enable or restrict the nurse leaders in 'taking a lead with clinical governance' were inclusive of a changing medical/nursing discourse, a changing role for women in Fiji society, the inclusion of the community of 'patients' in decision-making about health care, continuing political uncertainty, and, economically, international aid money to support health care reform. Alice expressed confidence that, within this changing system, nurse leaders could take a key role:

> *It feels good to be one of the nursing leaders in this position. You're really part of the progress in developing this country…I think we are moving in the right direction, in the strategies that we have in place, I feel, I strongly feel, that we are moving in the right direction.*

For Bronwyn, how the nurses interacted themselves, both from their own volition and as members of a social group, was vital. She said: 'your enthusiasm must be the same from Day 1 to the day you retire from the Civil Service', and she also spoke of her own responsibility: 'I know there's work to be done. Somebody needs to lead this. To me, that's the best satisfaction that I can have'. The Fiji Ministry of Health was

changing and the nurse leaders were changing along with it. Their capacity to lead had grown as the structural system of the Ministry changed and as they became more educated and empowered. As one participant said, when doubting her capacity to lead at times:

> *I look through life, I look back and…'what have I done, what have I achieved this year?' You know, I don't think I have achieved much this year or last year…But when I put things on paper then I realize, yes, we have done. Not for me, but for nursing…We have done this. There has been development in this area, yes, so this is so –* ***then you realize that maybe you are leading, maybe you are leading****.*

The implication here, the claim she was making to me and to a wider future audience was that despite her doubts she kept going. This was consistent with the nurse leaders' continued reference to taking action in order to achieve their aims. With action would come an increase in the recognition by themselves and others that they could take a leading role in health care in Fiji.

Summary – Analysis and Findings

The aim of this analysis was to immerse myself in the rich description obtained from interview data, field notes, my reflective journal and the myriad of literature that provided a wider system perspective to what was happening for the nurse leaders. Carspecken's methodology and Habermas's theory of communicative action provided excellent platforms from within which to review what the participants had been telling me, what I was seeing and thinking about myself and other things that were happening in Fiji at the time of the study. The three themes: 'Finding our voices: understanding that we are powerful; 'Legitimizing our role as the facilitators of best patient outcomes'; and 'Recognition of our capacity to take a leading role in health care' emerged from the interview data over an extended time period, as I spent many months in the 'code mines' (Glesne & Peshkin, 1992) being closer to and then more removed from the data.

Chapters 4, 5 and 6 provide the basis for more detailed discussion in Chapter 7 about what I found, including further information about the findings and will lead to recommendations for the future. Obviously, the nurse leaders spoke of many things during the course of the interviews and beyond. The themes that emerged during analysis however, were essentially about how the introduction of the clinical governance framework, as well as other aspects of health reform, had changed their professional lives generally in positive and empowering ways. Despite the challenges and as can be seen, there were many, their sense of being liberated through a having vehicle (clinical governance) that they could use to achieve their primary goal as nurses, good and safe patient care, was the overriding topic that they introduced persistently in the interviews. Being empowered themselves, being educated, improving conditions for the nurses, learning to be multidisciplinary and taking an increased leadership role were important, but they all appeared to have the single aim of ensuring the delivery of optimum health care for the community. They saw this as happening through enhanced dialogue with the community (patients) and an increased customer (patient) focus.

Finally, before moving on to Chapter 7, it is vital to consider what happened with this research in terms of Habermas's theory of communicative action. Alvesson (1996) says:

> The fact that there are certain aspects that cannot be captured by the theory, and that the theory itself cannot solve all the problems or avoid all the contradictions, does not mean that it cannot throw light on some important aspects of social conditions and relations. (p. 148)

The world had not become a utopia for the participants. Life as nurse leader in the Fiji Ministry of Health remained a challenge, as is nursing leadership throughout the world. What did happen was that they had an opportunity to review a new system of health care (clinical governance) and to reflect upon the impact of the introduction of that system on their professional lives. This led to an increased awareness about 'what was going on' for them, with the consequent opportunity to contribute to altered social structures that would enhance their own lives and those of the community of Fiji.

The findings can be briefly summarized as follows:

Table 4.2: Findings **Theme 1**	**The clinical governance framework has contributed to the changing role of nurse leaders in Fiji:**
Finding our voices: understanding that we are powerful	• Through the recognition that Western influence in Fiji has had both adverse and favorable effects on the nursing profession • By increasing nurse leaders' opportunity to be heard as leaders within the Fiji Ministry of Health • By empowering nurse leaders through increased opportunities for both nursing and multidisciplinary education • Through the recognition that young leaders can contribute in Fiji • Through the recognition that health professionals in Fiji make their own decisions about health services in Fiji
Theme 2	
Legitimizing our role as the facilitators of best patient outcomes	• Through the recognition that as nurse leaders become more empowered, they will in turn empower the nursing profession • Through the recognition of a strong link between improved conditions for the nursing profession and safer patient care • Through a recognition of the complexities of improving conditions for the nurses in Fiji • Through an increased focus on customer (patient) in the delivery of health care • By facilitating nurse leaders increased reflection upon both individual and systemic issues which enable or prevent a nurse from delivering optimum patient care; and the nurse leaders' role in enabling nurses
Theme 3	
Recognition of our capacity to take a leading role in health care	• Through an increased focus on the multidisciplinary nature of the delivery of optimum health care • By facilitating nurse leaders' increased reflection on barriers to improved care; leading to the ability to take appropriate action to overcome identified barriers (Barriers identified inclusive of resistance to their leadership; the need for effective communication with all levels of health staff; migration of nurses out of Fiji) • Through reflection upon what constitutes effective nursing leadership internationally. • By empowering nurse leaders to take a key leadership role in improving health services in the Fiji Islands

Chapter 7
'Re-negotiating our place in health care' – A DISCUSSION

In the days that followed, Jonathan saw that
there was as much to learn about flight in this place
as there had been in the life behind him.
But with a difference.
Here were gulls who thought as he thought.
For each of them, the most important thing in living
was to reach out and touch perfection in that which
they most loved to do, and that was to fly.
(Bach, 1970, p.53)

Introduction

This chapter discusses the findings in light of the current literature pertaining to clinical governance and nursing leadership, with particular reference to the situation in the Fiji Ministry of Health. The study investigated the impact of introducing a clinical governance framework for the nurse leaders in Fiji. In doing so, identified gaps in the knowledge about what such a system means for a developing country have been identified. The six participants and others who provided information in more informal ways, enabled the discovery of knowledge that, while supporting some findings of previous studies, also added new information which contributed to understandings about the place of nurse leaders in providing a safe and effective health service for the community in a developing country. While there is a significant literature concerning clinical governance, it is sometimes inappropriate to transfer such findings to another context or country. Nevertheless, the findings do have resonance with past studies as well as contributing new knowledge. My use of a critical theory approach to the research, particularly the Habermasian lens, has enabled me to produce a number of key themes in this study. Analysis has resulted in useful information about what it currently means to be a nurse leader in Fiji and the possibilities for greater empowerment, which has been contributed to by the introduction of the clinical governance framework.

The literature, which has assisted to inform this study and the findings, both within the literature review chapter and in the findings chapters as it was used to enhance

understandings of the findings, provides a crucial link between previous research and scholarly literature and this study.

Discussion of the findings is presented consistent with Table 4.2 and areas of agreement and difference in terms of the existing literature are highlighted. The three major themes are discussed and ways in which the clinical governance framework has contributed to the changing role of nurse leaders, illuminated. The first theme 'Finding our voices: understanding that we are powerful' provides the basis for the initial discussion. Consistent with previous literature, findings concerning the impact of colonization on the nurse leaders, the increased 'voice' of nursing as part of the clinical governance agenda, the vital role of education for health care leadership and the importance of previously colonized countries making their own decisions about health care are highlighted. In addition, new findings about the significance of these elements, where this is pertinent to Fiji are explored, including the emergence of the young leader.

The second theme: 'Legitimizing our role as the facilitators of best patient outcomes' continues the discussion. Previous literature concerning the empowerment of nurse leaders and what this means in terms of empowerment of the nursing profession, provides a framework for identifying new knowledge in this area for Fiji. The link between improved conditions for nurses and increased patient safety is further explored, once again in terms of the particular situation in a developing country like Fiji and the complexities of improving nursing conditions in such an environment. Enhanced customer focus in the Fiji health system is consistent with previous international literature, but once again the special circumstances in Fiji provide new knowledge about what this means for the Western Pacific. Surrounding all of these findings is the perceived ability of the nurse leaders to be increasingly reflective about their situation, enabling them to take action for improvement.

Theme three: 'Recognition of our capacity to take a leading role in health care' provides the final basis for this discussion, as the issues of becoming multidisciplinary, overcoming barriers to improved patient care, discussion of effective nursing leadership and the intention of the participants to take the leading role in health care, are compared with the literature. It should be noted once again

that while some findings are consistent with existing literature, some are new and all, in some respects, provide new knowledge because of the setting for this particular study.

The methodology revisited

In order to appreciate the perspective within which this discussion occurs, it is important to recall that as a critical researcher, I view "organizations as social historical creations accomplished in conditions of struggle and domination" (Alvesson & Deetz, 2000, p.83). Carspecken's stages for critical qualitative research provided the opportunity to obtain thick description about what was going on and to undertake detailed analysis of the data. Importantly, explaining the findings in terms of the wider social system that influenced the nurse leaders and the Fiji Ministry of Health provided a comprehensive understanding about what had been happening and what the impact of the clinical governance framework had on participants' professional lives. In addition, the Habermasian lens used to scrutinize the data included the awareness that domination indicates the absence of an ideal speech situation. The aim of empowering research such as this is to move with participants towards communicative action within the organization. Here, rather than merely living within a lifeworld dominated by potentially destructive systems, members of the organization are able to reflect upon their situation in order to change it. The intention is that members are better able to check "the truth, legitimacy, sincerity, or clarity of claims made on them by established structures of authority and production" (Forester, 1983, cited in Alvesson & Deetz, 2000, p. 94). In doing this, participation in discourse as a community of equals becomes possible.

Finding our voices: understanding that we are powerful

'Our past nurses looked at Florence Nightingale'

The effects of colonization proved to be a recurring theme throughout participant interviews and otherwise. This was particularly important from a critical theory perspective, where the aim of moving forward from "ideologically frozen understandings" (Comstock, 1982, p.388) was paramount. Participants spoke of the influences of the West not only in terms of continuing effects on the nursing profession, but also about what colonization meant for Fiji as a nation. The influence of Christianity proved particularly significant for nursing, with references to the

influence of Christian churches permeating both the available literature and media reports in the country. This finding is consistent with previous literature. For example Leckie (2000, p.198) points out that "the baggage of culture and colonialism is persistent", and this is similar to Brison's (2003) reference to the tensions contemporary women face in Fiji in terms of their past and present way of being in the world. Nevertheless, while Brison found that rural women struggled with the modernising effects of globalisation, the nurse leaders in this study had a different opinion. They reflected upon what 'being from Fiji' meant for them, both culturally and from the perspective of colonization, but claimed they were determined to take aspects of these effects and use them to re-negotiate their relationship with both their traditional culture and with the West. This re-negotiation was aimed towards empowering themselves by taking what they needed. It was about re-inventing themselves as contemporary women of Fiji who would take their place alongside the men in developing a better health system for the country. While this is still problematic for them, given a long tradition of male domination as well as an extended history of passivity for the nursing profession, their reflection upon such processes is a vital step to achieving greater independence in their roles.

Knowing that they wanted empowerment did not of course automatically guarantee that this was conferred upon them or that they could immediately claim it. Rather, the knowledge that it was possible reflected progress along a continuum from relatively disempowered to the understanding that increased power was achievable. In terms of Habermas's ideal of communicative action, part of the problem had long been that Western colonization of Fiji imposed a system of values and ways of living that local people were often obliged to adopt at the expense of expressing their own legitimate ways of being in the world. This was further complicated by women's traditional subservient place in Fiji society. A recent review of the significance of the media in shaping Fiji is also significant. Connell (2007) found, in his review of the influential column "People" in the *Fiji Times*, that "model lives [are seen to be] modern lives as modern values replace the old" (p.102). Thus, emerging ideas about good citizenship in Fiji are consistent with the nurse leaders' notions of themselves as contemporary women. Indeed, Connell found that women are portrayed as being able to take part in this new order of participating and progressing to achieve both social and organizational success. This is very important for the participants, because they do

continue to deal with traditional and Christian ideals of 'femininity' and as previously noted, are obliged to 'put family first'. A changing discourse of modernity, nevertheless, enabled them to give themselves permission to change prevailing ideas about what it means to be a woman and to seek success in their professional lives. Whether or not 'modernity' in this sense is desirable for women of Fiji, or in some way will create forms of alienation from the dominant culture resulting in increased anxiety and depression (Outhwaite, 1994) must be recognized. Participants' claims about being contemporary women must be referenced against the continuing issues they deal with as people attempting to assimilate elements of Fiji culture with those of a Western system of nursing and nursing leadership. The clinical governance framework has been recognized in some ways as a vehicle of empowerment but is of itself a bureaucratic tool that may or may not reinforce oppressive structures in Fiji. The nurse leaders said they hoped it would assist themselves and their constituents to achieve more of 'the good life' (Holmes & Warelow, 2000). They are claiming that, thus far, this appears to be happening. The limitations of this research, obviously, as will be discussed further, are around not only the sincerity of such claims, but also the question of whether similar claims would be made by others who are not in leadership positions within the Ministry of Health. Referring to Carspecken (1996), it can be noted that the relationship of system to the nurse leaders' experiences included the effects of British colonization as well as elements of the lifeworld of Fiji.

'They invited us to go and present nationally…it was a beginning'

'Having our voices heard' was an important theme here, where all of the participants spoke of having increased opportunities to engage in more equal debate about health care policy and practice as a result of health reform. The increased voice of nursing as part of clinical governance and improving patient safety has been widely discussed in the international arena (Aiken et al., 2001; Currie & Loftus-Hill, 2002; Grainger et al., 2002; Sheahan et al., 2007). Whilst nursing and patient safety have received enormous attention in developed countries, there is a lack of literature reporting on what it means in developing countries if nurses claim their power and use that new-found influence to improve conditions for their patients. Of interest also is the new finding that participants would use elements of the West to strengthen their positions as health care leaders. So the potential for the nurse leaders to use the West to, in effect, overturn the impact of colonization, is striking.

Philomena's comment about being invited to present her ideas for the health service is particularly important here. General notions of 'empowerment' are insufficient to explain what being empowered meant for the nurse leaders. They had a very long history, as noted earlier, of not being heard within the Ministry of Health. This finding of increased empowerment is consistent with previous studies. Lewis and Urmston (2000) make a fascinating connection between health and empowerment and organizational empowerment and what this means in terms of a change to the role of health professionals, including increased confidence and self-efficacy. The invitation to present nationally was symbolic of a role change for the better for the participants and affected their perception of themselves in positive ways. From Kanter's (1993) research comes the suggestion that organizational structure has plenty to do with what people do at work, and their attitudes towards what they do. The nurse leaders were experiencing a change in the structure of the Ministry, in that they were increasingly engaged in a discourse around health care policy. Again, such claims or developments must be considered against a long tradition, both in Fiji and elsewhere, of nurses more often being observers of health policy development at best and passive recipients at worst. Nevertheless, the changing discourse did provide a feasible opportunity for increased decision making and has contributed to the good sense that the nurse leaders can contribute to improving the situation for themselves, for the nursing profession and for the patients.

'It is seen that they are learning together'

The focus on education as a means of improving their situation was prominent for participants throughout the study. Literature around clinical governance includes this strong focus on the importance of education for the clinical governance agenda. Boggust et al. (2002) make a connection between education and the closer involvement of leaders in clinical care. Many of the findings in this study are consistent with previous studies and other literature in this area (Clark & Smith, 2002; Frankel, Leonard & Denham, 2006), in terms of the role of educating for clinical governance. However, in terms of the context of Fiji, the finding about the necessity for education to be multidisciplinary is new and has important implications for the Western Pacific and for elsewhere. If one of the key components of good clinical governance is the need for a multidisciplinary or team approach to health care (Currie & Loftus-Hill, 2002; Ferguson, 2002; Firth-Cozens, 1999; Heard et al., 2001; Nicholls

et al., 2000; Sanderson, 2000), then the importance of shared education becomes apparent. What is new here is the nurse leaders' perception that if the community sees that they are being educated alongside the doctors, then this becomes another way in which they will increase their power both within the health sector and in Fiji. For them, increased power equates to better patient care, so education with the doctors was viewed as a means to this end. Williamson's (2005) study linking shared governance with work-based learning is informative, in that she found 'protected' time spent in learning transformational leadership behaviours can lead to better leadership. Of most importance here is her notion that such learning should be shared, and should encompass the multidisciplinary team. Multidisciplinary teams who engage in shared reflection, action learning, coaching and mentorship (Williamson, 2005) develop better relationships among team members and a sense of being valued within the organization. The multidisciplinary workshops in Fiji are an initial step to such shared governance and this finding, when compared with the literature, is a sound basis for recommending further development in this area, as will be explained more comprehensively in chapter eight of this thesis.

A study by Ginsburg et al. (2005) is also valuable, in that they found that formally educating leaders to promote a patient safety culture resulted in significant cultural improvement. While their study involved nurse leaders only, rather than being multidisciplinary, the implications are that educating all health professionals in leadership positions about patient safety is desirable and enhances a patient safety culture. The participants in this study, who had been involved in multiple clinical governance workshops in Fiji, clearly identified that they had moved away from a culture that focused more on the staff of the Ministry than the patients and towards a situation where the future focus would be on the patient. Yet such a utopian ideal is far from the reality of any health system in the world and Fiji is no different. What they had achieved was an initial step toward multidisciplinary education, with the possibility for more. Their passion for education was obviously mirrored by the outcomes that education could produce. This is interesting, given Connell's (2007) contention that "emphasis [in Fiji is]…on the process, usually through individual effort, and not on the outcome" (p.89). Rather, the emphasis for the participants was on team effort, with clear links made to what this effort could do in terms of patient outcomes. Their ability to move from a focus on process will be a challenge requiring

major cultural change within the Ministry of Health. My observations included those of an organisation which did focus on process, with attendance at 'workshops' being seen as a reward and an opportunity to socialise as well as learn. Translation of learning to practice with real effects on patient outcomes is still a journey that personnel within the Ministry of Health are sometimes planning for rather than taking. It will require that which Holmes and Warelow (2000, p.179) refer to as a "praxis [which] is also about one's relationship with the wider community". The nurse leaders claim that they want this. In order to achieve it, the culture of the Ministry will also require significant adjustment.

'It's our culture that we get to listen to the older people, the elders'

One conspicuous theme that emerged in this study concerned the tradition of nurses having to wait until relative middle-age before they were able to assume leadership positions. There is an existing literature around strategies to deal with the issue of the ageing nursing workforce from a global perspective (Buchan, 1999; Lavoie-Tremblay et al., 2006), but a general absence of any studies concerning attitudes towards younger nurse leaders. All of the participants in this study referred to 'having to do your time' in Fiji before being promoted to a leadership position. Five of the six participants made overt reference to wanting this to change, and were quite explicit about younger talented nurses being given the opportunity to assume leadership positions, rather than having to proceed through the Public Service 'ranks and files' over many years. This is significant for Fiji, where respect for elders is a strong tradition which is played out among nurses. Order of rank, or a hierarchy, is an important element of social organisation in Fiji, whether this be as part of the ritual of *yaqona* (kava) drinking (Sharpham, 2000), or in terms of the social significance of the chiefly office (Nayacakalou, 1975). To question this hierarchy is revolutionary for the nurse leaders, whether this is from a traditional Fijian perspective or from the long Nightingale tradition of nursing. The sense from them is that they know this will be difficult, and that having young people in leadership positions challenges much of what has been valued in Fiji nursing. Nevertheless, their courage in questioning such an entrenched value is indicative of the sort of claims they made throughout the study insofar as they were determined that the future of Fiji health was going to be better than the past. This finding suggests that there should be discussion within the health professions about earlier promotion, rather than, as happened during the time of the

study, having a situation where the majority of the nurse leaders would retire together, without sufficient succession planning. Ageism in whatever form it takes, whether this be a Western bias against the elderly, or bias against youth in Fiji nursing leadership, limits the possibilities in the world and indeed, in nursing, for self-determination by individuals of the 'wrong age' (whatever that is) to best contribute to nursing practice and patient care. Lavoie-Tremblay et al. (2006) have suggested that organisational arrangements be made to accommodate older nurses continuing in the workforce if they so wish. The challenge for Fiji, as it is elsewhere, is concerned with recognising the social constructedness around the question of age so that the profession can maximise its potential by changing the discourse concerning the 'right age'. Also, it is always possible within a culture that equates older age with wisdom that elders can make mistakes and this poses a continuing test for Fiji nursing.

'To able to apply the new concept locally – to have the cultural identity of the place where you're from'

Colonization by Western countries has wrought havoc for indigenous peoples worldwide. The notion that "'less developed' people…should not be allowed to speak for themselves, until judged 'progressed'" (Jack & Westwood, 2006, p.490) persists. The literature relating to this problem mirrors concerns raised in Fiji, whether this is Rokotuivana writing about former colonizers continuing to set the agenda for Fiji immediately following independence in the early 1970s, or the Chief Executive Officer of the Ministry of Health voicing concerns about patriarchal international aid agency staff in 2005. From the archives comes the voice of colonialism where McLaughlin (1944, p.1122) noted that the Fiji School of Nursing curriculum of the time had to be "simplified…and is modified to tropical and native needs". Linked to previous discussion about participants' use of the West for themselves, they insisted that local people in Fiji should make the decisions about Fiji's health system, and that foreigners were simply invited guests who could assist on Fiji's terms. This is a relatively fresh idea, given Leckie's (2000) reference to the passivity of the nursing profession and is more like Jalal's (2002) proposal that women should have a major role in developing policy in the country. Of interest is that it is at odds with Nilan et al.'s (2006) study of career choices for Fiji school students, where 'nurse' is listed alongside, for example, 'farmer', 'reverend' and 'pastor' as a para-profession rather than profession, presumably with less decision making power than the professions of

'doctor', 'lawyer' or 'resort manager'(!) The participants did not see the future of Fiji health care this way. When speaking about the people of Fiji making they own decisions, they certainly were including doctors, allied health professionals such as dentists and administrative staff in their discussion. Nevertheless, as nurse leaders, they saw themselves as people of Fiji who would take a key role in decision making for the country. This is an important finding, because, once again, the Western Pacific has traditionally been a place where women and in this case, women who are nurses, have not generally previously played a major role in structuring Ministries of Health.

Postcolonial theory would suggest that "one of the main features of imperial oppression is control over language" (Ashcroft, Griffiths & Tiffin, 2002, p.7) and Coral's suggestion that 'it all messes up like a stew' when concepts are imported from the West and applied unchanged in the Fiji situation is significant. The participants gave several examples of how *kai valagi* had come to Fiji, notwithstanding that they probably had good intentions, and told the people of Fiji how they should organize their health care system. Invariably foreigners brought with them Western systems which were never going to be appropriate for the Fiji context. Rather, the participants were willing to listen, and to read about and discuss these systems, but insisted on local application, and, importantly, on decision making by the people of Fiji. Local decision making is a move toward discursive practices that overturn the legacy of colonialism of previously legitimised infrastructures that continue to support the colonial project. The hegemony of the West persists despite the rhetoric of postcolonialism and the nurse leaders of Fiji are participating in turning that rhetoric into a new reality. The world of their health care system is not 'frozen in time' in the sense that neither traditional health care practices nor Western imposed medicine forms the basis for the system. Rather, the culture of Fiji changes as do cultures across the world, as historical, social, political and economic conditions (Mohammed, 2006) continue to impact upon what is going on in the country. From a postcolonial perspective, the key point here is that the people of Fiji insist on controlling what happens there, despite a reliance on international aid and goodwill to continue to improve the health care system. Such insistence must be tempered with the knowledge that 'local decisions' will not necessarily be 'perfect decisions'. Western influence has obviously been problematic for Fiji, but as has been discussed, has also provided

some benefits. Local control is desirable, but must be recognized as containing the possibility of yet more disempowerment of vulnerable members of the organisation. The necessity for continued reflection and continued efforts toward providing for a just society exists, no matter who is making the decisions.

Having said this, it is crucial to note that these participants refused to be exotocized according to Said's discussion about the West and the Other (Mohammed, 2006). Instead they present as individual women who come from Fiji but have a range of different experiences as people and as nurses, in the same way that I, as a researcher from Australia, do. They are, in ways that I am not, members of a network who

> share experiences as peoples who have been subjected to the colonization of their lands and cultures, and the denial of their sovereignty, by a colonizing society that has come to dominate and determine the shape and quality of their lives, even after it has formally pulled out. (Tuhiwai Smith, 1999, p.7)

The participants' determination to now shape the quality of their health services is a way of 'leading back' in the same way that 'researching back', 'writing back' or 'talking back' is characteristic of the decolonizing or postcolonial project (Ashcroft, Griffiths & Tiffin, 2002; Tuhiwai Smith, 1999). This changing culture towards increased empowerment was to have implications for not only the nurse leaders, but also for the nursing profession and the patients of the Fiji Ministry of Health.

Legitimizing our roles as the facilitators of best patient outcomes

'In your days, be with them, talk with them'

The participants spoke of a hierarchy of nursing, where nurse leaders were removed not only from the nurses providing clinical care, but also from the patients. They perceived that this contributed to poor patient outcomes in a number of ways. Chief among these were the difficult conditions in which nurses carried out their work. The findings in this area are consistent with the literature insofar as poor staffing and a difficult physical environment led to problems of stress and high absenteeism, difficulties in retention and resultant adverse events in the health sector (Aiken, 2001; Aiken et al., 2001; Kalish & Aebersold, 2006; Kralik & Smith, 2006; Rogers et al., 2004). In this study, an initial phase identified by participants to improve conditions for the nurses was to spend more time with them. They wanted to do this in order to develop better relationships and to better understand the problems the nurses faced.

This is consistent with Shirey's (2004) idea of leaders developing closer personal relationships in order to increase nursing empowerment. Closer personal relationships between leaders and followers have been found to increase follower self-esteem and coping skills (Lewis & Urmston, 2000) and confident, satisfied nurses provide better patient care. The discourse of nursing as a previously undervalued workforce in Fiji was extremely important in this study, especially so because of the impact this had on patient care. Changing this discourse, as was happening as a result of health reform, came about as empowered nurse leaders felt more able to challenge nursing conditions in order to improve them. The finding that effective leadership was a key construct for the provision of good nursing care mirrored the literature in this area (Thompson et al., 2005; Williamson, 2005) and for the nurses of Fiji has important implications for the future of the profession and indeed, for the community. McKinley et al. (2007, p.21) reinforce the link "between effective management and positive patient outcomes" in their discussion about falls prevention in hospitalised patients.

While available data about specific adverse events in Fiji is not yet at the stage where it can be compared with the McKinley et al. discussion, the necessity for effective leadership and management was demonstrated clearly by the participants in this study. The issues that nurses have to contend with in Fiji are often environmental and include, as Dorothy and Philomena pointed out, dangerous inadequacies in the infrastructure for both hospital and community health nurses. Lin and Liang (2007) provide a useful discussion, which is consistent with the findings in this study, about the necessity for nurses to have adequate resources for their work. They comment on the fact that

> nurses are those who spend most time at the 'sharp end'. The sharp end is the interface between provider and patient where multiple layers of care may either block or allow errors to penetrate, resulting in accidents. Decisions, policies, procedures and protocols at the 'blunt end' of administration, formal and informal turf battles, communications issues, and so forth represent how the nurse-patient will interact at the sharp end. (Reason, 1990, cited in Lin & Liang, 2007, p. 26)

The nurse leaders in Fiji are often at the 'blunt end' in this sense and their assertions that they had often been too far removed from the 'sharp end' are significant. A previous sense of disempowerment contributed to their avowed ignorance about

'sharp end' needs, as they followed an imposed system of maintaining their distance from the nurses. Health reform, including the clinical governance project, contributed to changing this and their better sense of themselves gave them courage, they said, to move closer the 'sharp end' and begin to more thoroughly investigate the challenges facing the nurses. This was an honourable intention, but one that involved major change for some of the participants, who had long been part of a rigid hierarchy within the nursing profession. While I saw more evidence of 'open doors' than I had in Australia, a long history of passivity on the part of the nurses still existed and conditions within which the nurses worked were problematic. The possible differences between what the nurse leaders told me they would do and what would actually happen should not be minimized here. Actors make claims to preserve a sense of their own positive identity and the group of nurse leaders, subject as they were to the influences surrounding the introduction of the clinical governance framework, may have felt compelled to reconstruct nursing in keeping with the requirements of the new system. Thus the vision of the 'modern nurse leader' was one which encompassed concern for the nurses and the conditions in which they worked. From a Habermasian perspective, this equates to a restructuring of the society, comprising lifeworld and system, of Fiji nursing.

To speak against or to appear to behave against this new version of the nurse leader could be a threat to identity and result in a sense of loss of meaning, absence of social solidarity or indeed, psychopathologies (Outhwaite, 1994), rather than a good sense of social integration within the nurse leader group. Thus, the complexities around improving nursing conditions should not be minimized. Attempting to provide adequate resources for health care in a poor country like Fiji is infinitely more difficult than it is for those developed countries that complain of under-resourced health services. Nevertheless, as members of the contemporary nurse leader group, participants were setting forth on a journey to, consistent with the literature in this area, "understand what it is about nursing that affects outcomes" (White et al., 2005, p. 17). This Canadian study (White et al., 2005) investigated the relationship between nursing practice and patient outcomes and was inclusive of a comprehensive review of nursing conditions. Importantly, the ability of administrators to actually find out what the nursing conditions were proved a challenge for them and future research is planned in this area.

The relationship between nursing leadership and nursing conditions is also consistent with the Aiken et al. (2001) study of hospitals in five countries, where they found that "nurses want more communication with management about the allocation of resources and the creation of an environment that is conducive to high-quality care" (p.51). In assuming more responsibility for being closer to the nurses and finding out more about their conditions, the nurse leaders were exposing themselves to the potential that they might not be able to provide adequately for the nurses. Nevertheless, once again, it was indicative of their courage that they chose to pursue this agenda anyway and to deal with whatever the outcomes proved to be. Habermas's notion of the ideal speech situation equates to such a choice. The nurse leaders intended to engage in more equal discourse with the nurses, to provide the avenue for healthy debate about what was needed for the Fiji Ministry of Health. They said they were available to the staff, and, although they might not achieve all that was asked of them, due to economic and other constraints, were showing *loloma* for their constituents. Constraints that they faced, other than that of having insufficient funding, were essentially about a radical change, as noted previously, in the way that nurse leaders communicated with the nurses. Shared understandings in a Habermasian sense (Holmes & Warelow, 2000) had been less of a feature of organisational life in Fiji than had technical interests whereby the nurse leaders 'managed' and the nurses did the work. They say they want this to be different. The challenge will be about achieving such cultural change.

'Nursing leaders…are looking at safe patient care. You're looking at nurses and doctors actually providing this care for patients at the frontline'

The nurse leaders made a clear connection between their own empowerment, empowerment and improved conditions for nurses and safer patient care. The clinical governance framework was perceived as a vehicle through which this could happen. Safe patient care obviously means providing effective care and more than that, usually means being able to provide increased funding to improve systems as well as being able to effect changes to the organisational culture (Duckett, 2007). Patient safety is obviously concerned with managing risk and with the reporting of adverse events and 'near misses' (Vincent, 2001). The management of risk involves developing an organisational infrastructure which encompasses "developing simple but effective systems and processes that capture the performance of individuals, teams,

organisations and devices that work well and not so well" (McSherry & Pearce, 2007, p.54). There is a plethora of literature concerning such systems and the particular role of nurses in relation to them (Considine & Botti, 2004; Elfering, Semmer & Grebner, 2006; Kalisch & Aebersold, 2006; McPhee, Ellis & McCutcheon, 2006; Rogers et al., 2004; Scott et al., 2006). Many of the findings in this study are consistent with previous studies. However, in terms of the context of Fiji, some have added new information with important implications for Pacific Island nations and elsewhere. For example, in their study concerning whether or not young nurses reported safety-related events or otherwise, Elfering et al. (2006) found that work related stress, situations they referred to as those in which "people work under high demands and low control [where] events that endanger patient safety are experienced as more familiar, and more likely to recur" (p.466). The nurses in Fiji often work under extreme duress, with high patient to nurse ratios, failing equipment and a lack of basic supplies such as necessary medications for patients or sterile gloves for surgical procedures. Within this stressful environment, they are less likely to report adverse events.

Indeed, a review of reported adverse events across the three Divisions in Fiji (Stewart, 2006) revealed chronic under-reporting across the health system. In contrast with the available literature, which focuses solely on the work environment, there is a strange absence of investigation into how a nurse's home life might impact on his or her professional behaviour. A new finding from this study encompassed the notion that blaming the individual for mistakes was less useful than the nurse leader considering how aspects of a stressful home environment might impact on working life. Coral made the comment, when discussing nurse absenteeism that 'maybe she's got a young baby at home; her husband is not very supportive. She has to do all the household work before she comes to work. She can be tired'. This is rather dissimilar from the mantra of the West, which, while there is rhetoric around the idea of 'work-life balance', demands that nurses belong to the organisation during paid hours of work.

More similar was the finding that "lack of confidence, concerns about the effects of their involvement, and fear of retaliation" (Henriksen & Dayton, 2006, p.1540) was a pervasive reason for individuals not confronting others about issues of patient safety, or indeed, not reporting adverse events. Henriksen and Dayton make the crucial point

that maintaining the status quo and the tendency for groups to unquestionably follow the leader contribute to unsafe patient care. In this study in Fiji, participants referred to a previous pervading culture of focusing more on the staff than on the patients and indicated that this had occurred at the highest levels of the Ministry. Edmonson (2004) contends that it is local leadership behaviour that shapes the culture of an organisation. Additionally, Campbell (2004) states that developing countries can engage in improving the quality of care to patients despite the challenges associated with a lack of resources. In the Fiji Ministry of Health, the nurse leaders said that they were changing the ethos, both at Head Office and locally where a culture of patient safety was gradually being developed as a result of their efforts and to some extent those of their medical colleagues. Of vital importance was the move to empower the frontline workers through the provision of better education and more resources so that they would then provide better patient care. This changing culture was one of focusing on the patient, the 'customer', as the centre of the health service.

'*The client, the recipient of our care, that is, they'll get the best care'*

A focus on the customer proved to be a fresh construct in the world of the Fiji Ministry of Health. The challenge in Fiji as it is elsewhere was to be able to turn this intention to focus on patients into something approaching reality. The absence of the patient voice in health care in Fiji has been previously alluded to as has a focus on process rather than outcome in the provision of care including nursing care. Absence of the patient voice was part of "the very fabric of everyday life" (Alvesson & Deetz, 2000, p.87) and to change this was always going to be problematic. Gramsci's idea is significant here, with his notion of hegemony as extremely complicated and as being woven into the very tapestry of the environment (Alvesson & Deetz, 2000). Nevertheless, as noted earlier, the first patient satisfaction survey was conducted during the time of this study, which proved illuminating for the nurse leaders. Dorothy mentioned that this had contributed to a change in attitude for the better towards the patients. This is significant, given Darby and Daniel's (1999) contention that "given that most hospital patients cannot insightfully judge the value of the process technology used, they focus on the interpersonal interactions with professional service personnel" (p.272).

The clinical governance framework has an overarching ethos of customer focus and attendance at the clinical governance workshops proved to be an important element in changing the nurse leaders' views about customers. The key construct, however, is that patients have come to be seen as people who should have a say in how their health care is planned and delivered. This is revolutionary in Fiji and because the notion of the patient as an equal partner is health care is so new, studies into this phenomenon in the international literature essentially point the way for what may be possible in Fiji in the future. Certainly Wall and Window (2004) noted the relatively recent situation in the United Kingdom where patients were viewed as merely the "passive recipients of care" (p.71). Further, Bondas (2003), researching nursing leadership in Finland, notes the problems nurse leaders contend with in bureaucracies. She refers to the possibility that patients so easily become "an anonymous number in the health care queues" (p.249) and advocates for leadership with a major focus on the care of patients. Further, Hyrkas, Paunonen and Laippala (2000) and Squire et al. (2006) provide useful frameworks within which customer service may be considered in Fiji. Hyrkas et al., in their study of patient satisfaction, note that while satisfaction surveys may yield somewhat limited information, they do provide for an opportunity to examine trends in what patients are satisfied with. Further, Squire et al. take this further by "promoting on-going patient participation in specific improvement projects" (p.13).

From a critical theory perspective, Forester's (1993) review of public policy and planning is extremely useful. His take on involvement of the public in planning policy has its equivalent in the involvement of patients in planning for health care. He notes that

> organizationally, attention is framed by organizational mandates, responsibilities and precedents and reproduced through the concrete communicative interactions of organization members with one another and with the larger public. (p.31)

To focus on the customer is to involve this 'larger public' in all aspects of health care planning, delivery and evaluation. The reproduction of what happens in health care practice will be significantly altered if the patient is involved in the earliest stages of decision making around health care planning. Communicative action according to Habermasian theory should involve not only healthy debate with frontline workers in

the Fiji Ministry of Health, but also with the patients. The nurse leaders in this study have taken early steps towards this ideal. Their contention that empowering nurses will result in better and safer patient care is consistent with the existing literature and reinforces Forester's (1993) argument that to seek mutual understanding is a worthy goal for all stakeholders of an organisation. A patient actually having the opportunity to engage in discourse about health care is new for Fiji. This is an immensely encouraging finding and although in its infancy in the island nation, is consistent with Alvesson and Willmott's (1992) idea that the critical project is

> …a precarious, endless enterprise; [and] its believers fight continuously in order to create more space for critical reflection and to counteract the effects of traditions [and] prejudices…it portrays the emancipatory idea not as one large, tightly integrated project, but rather as a group of projects, each limited in terms of space, time and success. (p. 447)

Thus, although they are tightly related, empowerment of the nurse leaders could be considered as one crucial project, empowerment of the nurses as a second and empowerment of the patients as yet another. It was apparent in this study that reflection upon their own situation and those of the nurses and patients, had been enhanced through health reform and through participation in this study. It would remain to be seen whether the beneficiary of such increased reflection was going to be the patient, as the nurse leaders took action to improve health care practice.

Recognition of our capacity to take a leading role in health care

'I don't think nursing can ever be on its own, no it can never be on its own'

Becoming multidisciplinary proved a particular challenge for several of the participants. They spoke of 'loss' when describing this, while recognizing that partnerships with other health professionals was an absolute necessity for good clinical governance. The necessity for a multidisciplinary approach to the planning, delivery and evaluation of health care is well documented in the literature (Ferguson, 2002; Firth-Cozens, 1999) and for the participants, moving beyond medical dominance to achieve this aim was a particular challenge. Their sense of becoming 'lost' within a larger group of health professionals is a new finding and as noted previously, stems from their strong sense of solidarity about belonging to the nursing group. Findings that were consistent with the literature included the sense that multidisciplinary partnerships were going to be necessary in order to achieve best

patient care (Firth-Cozens, 1999). Also, although barriers still existed between health professionals, having nurses and doctors working together on the clinical governance agenda (Currie & Loftus-Hill, 2002) was seen to be the way forward for Fiji.

It is obvious that the two crucial issues here were the nurse leaders' own reluctance at times to become part of a larger group with the patient at the centre and also the threat that they posed to others in the Ministry when they demanded equal power. Coral's assertion that the nurse leaders in Fiji 'should be able to look outside and see what a major role that nursing in Fiji could take to be on a par with nursing practice worldwide' was resonant of a 'call to arms' to Fiji's nurses to fight for the right to have an equal say in health care policy and practice. It was extremely important that they also recognized that such change could take time, and their willingness to engage in long term evolutionary action was significant. If they had viewed the reversal of their new roles as General Managers as a failure rather than as simply a normal part of the change process, then the possibility of long-term change could have been more problematic. Instead, they saw the move to multidisciplinary health care with the patient at the central focus as a continuing project for the Fiji Ministry of Health, but one in which they would take a major role. This is significant, given Currie and Loftus-Hill's (2002) finding that participants in discussion groups about clinical governance in the United Kingdom spoke of the "hierarchy that still exists between nursing and medicine, where nursing is seen as subordinate" (p.42).

The discourse of medical domination remains reflective of Fiji nursing in the early 21st century. The possibilities for a multidisciplinary approach to patient care exist and health reform has been a contributor to such an approach. Shared education, participation at national executive forums and formalizing the Director of Health System Standards as a nursing post were new developments in this direction. The nurse leaders in Fiji clearly were, as Coral said they should be, part of an international movement to have all health professionals work in partnership for the good of the patient.

'And one of my biggest challenges here, Lee, is losing my skilled nurses'

The participants spoke of many barriers to their goal of improved patient care in Fiji. They described a Head Office that needed to have more knowledge about the frontline

health system as did Balding (2005) and Duckett (2007). They spoke of the particular problem of retaining a registered nurse workforce in a developing country which could not hope to provide the salaries and conditions that registered nurses achieve in the developed world. Indeed, the issue of the migration of registered nurses out of Fiji was an essential finding in this study for a number of reasons. In terms of potential nurse leaders, participants questioned the loss of sometimes their most experienced and talented nurses to countries that could afford to pay them more. This is a fraught question. Clearly, the nurses send remittance home which benefits the country (Brown & Connell, 2006). If they do return home, they often do so with valuable skills and nursing experience. Nevertheless, the loss of a skilled health workforce is a major problem for countries like Fiji and concerns raised by the participants mirrored those of other studies (Ross, Polsky & Sochalski, 2005; Thomas, 2006) insofar as migration out was an enormous threat to an improved health care system. Of interest in this particular study, however, was one of the participant's contentions that 'there should be something like soldiers for nurses. They go to Australia, they sign up for two or three years, and they should come back'. The problem here was that there was an acceptance of the situation, almost as though Australia had a right to these nurses and there was nothing Fiji could do about that.

From a Habermasian perspective, this indicates a terrible absence of an ideal speech situation, where the discourse is that the powerful West has an entitlement to take registered nurses, who have been educated at the expense of a poor country and use their skills for differing periods of time. There is an inference that only then can a nation like Fiji have their people back to benefit the home nation. Of course, individual volition is important here and the nurse also has an autonomous right to leave Fiji at will. So this is a complex situation. Nevertheless, countries like Australia also have an ethical obligation concerning recruitment from countries like Fiji and the World Health Organization's urging of governments to engage in more productive international cooperation is vital and moves closer to communicative action.

From the perspective of Fiji, Thomas's (2006) finding that nurses sometimes leave because they feel neglected within the health care system is especially significant. Although not mentioned by participants as a feature of this study, if this were so, then

more attention to nurses and the conditions in which they work might do much towards ameliorating the levels of migration out of Fiji.

'You want to foresee the future, to be able to anticipate – who is able to identify trends, to look at today to envisage what will happen in the future'

Effective leadership proved to be a strong topic of conversation for the participants. Clearly, leadership is the central tenet of clinical governance and the literature around effective leadership, including nursing leadership, is exhaustive. A useful framework within which to consider what it is that makes leadership effective comes from Bennis (1994), where he says good leadership is about:

> Ideas, Relationships and Adventure. Ideas are the basis for change, for re-invention, for…intellectual capital. Relationships have to do with outstanding people working in harmony and openness, where everyone feels empowered, where all members feel included and at the center of things, where they feel competent and significant. And Adventure has to do with risk, with a bias toward action, with curiosity and courage. And the challenge of leadership is to create the social architecture where ideas, relationships, and adventure can flourish. (p.xiv)

Bennis has been researching leadership for decades, as have Kouzes & Posner (2002) and their work is complemented by the research into nursing leadership and the relationship between good leadership and clinical governance, which has continued to inform nursing practice over many years. The findings in this study support much of what has been written about leadership to date, in that the participants spoke of the need to be visionary, to be closer to their followers so they understand what is happening for them and to work with integrity to keep the promises they make to their constituents (Alarcon et al., 2002; Kitson, 2001). In addition, there was a strong inference throughout our conversations that they rated self-awareness highly, including an ability to reflect upon their role as leaders and this is consistent with Fletcher's (2006) notion of self-awareness. As importantly, the nurse leaders noted that the nursing profession in Fiji had been subject to medical dominance and that they indicated this was changing as a result of their increased sense of empowerment. Fletcher points out the need for nurse leaders to "critically examine and understand our collective reality: our history, our oppression, our gender issues" (p.56). It is insufficient to discuss pleasant ideas about being an effective nurse leader and influencing the clinical governance agenda, without reference to domination and the need for empowerment.

The nurse leaders in Fiji needed to recognize their former place in the health care hierarchy and they did so. They spoke in a revolutionary sense about the need to liberate themselves, the nurses and the patients, from oppressive forces that contributed to less than optimum health care. Studies by researchers in Hong Kong and Chile are useful here. Chan (2002) examined factors that influenced nursing leadership in Hong Kong over the fifteen year period between 1985 and 2000. She was specifically looking at the major reform of Hong Kong nurse education. Her key findings were that barriers to effective leadership were inclusive of medical dominance, issues around the socialization of nurses and limited education opportunities for nurses. These were consistent with the findings in Fiji. Chan also found that social, economic and political environmental changes, including changes in the health care system and to universities facilitated better nurse leadership. This is a significant study because Hong Kong's position as a relatively recent British colony is very similar to that of Fiji in that Hong Kong's nurse leaders are functioning in a postcolonial setting. Importantly, lack of education for leadership, linked with the medical profession's objections to education reform for Hong Kong's nurses, were key factors related to oppression of nurses in that country. In Fiji, shared education for leadership with the doctors proved an initial step towards empowerment.

The situation in Chile was also reminiscent of Fiji, where Alarcon et al. (2002) found, in their study of nursing leadership effectiveness, that "knowledge of interpersonal relationships, personal attributes, and futuristic vision of the leaders, is the main component of leadership" (p.338). This was very similar to the findings with the nurse leaders in Fiji where participants indicated that having closer relationships with the nurses and being visionary were key constructs for the successful leader. They also commented extensively about personal attributes needed for leadership, describing individual motivation for life-long learning as a major feature of the effective nurse. Ideas about effective nursing leadership in Fiji are nevertheless tempered by the knowledge that such a "revolutionary society must avoid the historical fatalism of the so-called advanced industrial countries that decree that Third world history shall only repeat their own" (O'Neill, 1985, p.71). Rather, the nurse leaders are leaders *for* Fiji, once again taking those elements of the West that will best serve their own interests and those of their country and simultaneously rediscovering local ideas of *loloma* for greatest leadership effectiveness. Being leaders for Fiji,

then, meant operating within existing institutionalised hegemonic structures and traditional ideas of leadership and simultaneously being the sort of modern leaders promoted within the discourse of health reform. Coral's comment that Fiji nurse leaders should look at the international evolution of nursing leadership ('so a nursing leader in Fiji should be able to look outside') points to the tensions involved in being the sort of modern nurse leader which health reform demands one should be. The danger exists here that old oppressive structures are simply being replaced by new ones.

'Then you realize that maybe you are leading, maybe you are leading'

The intention of participants to take a key role in health care leadership was a crucial finding in this study. Some important research has been undertaken into the characteristics of clinical leaders (Cook & Leathard, 2004). However, the literature around 'executive' leadership, which better describes the participants' roles, often tends to be more anecdotal or opinion based (Cook, 2001). This qualitative study has clearly identified the nurse leaders' perceptions of what it was that made them good executive leaders. Characteristics discussed or inferred were those of being visionary and future focused; being able to lead in an environment of change; being personally available to both staff and patients; being influential in terms of the health care system culture; having both a strong nurse and patient focus; and being resilient in that they had the courage to continue despite adversity. Importantly, they also noted that they needed power within the system in order to be able to demonstrate these good characteristics. Empowerment for them meant having the ability to take a leading role within the health system. This became more of a possibility because of several crucial changes that were occurring in Fiji. One was a slowly changing nursing/medical discourse, where both nurses and doctors were being educated for leadership together, with the increased possibility that they could take a leading role together in the Fiji Ministry of Health concerning the clinical governance agenda. This is reflective of an international movement towards increased equity between the two professional groups although it is yet to become close to reality. One of the greatest threats to this possibility in Fiji occurred around the introduction of clinical governance itself.

Successful introduction of the framework, which translated into better outcomes for patients, would lend support to an empowered role for nurse leaders. Negative

outcomes related to clinical governance could threaten that role. Negative outcomes in a poor country like Fiji could well include insufficient resources to fulfil the promises of clinical governance. Raised expectations related to health reform are always going to be problematic. As has been clearly seen in countries like Australia, where broken promises to meet elective surgery and waiting list targets are met with cynicism and sometimes violence on the part of health care staff and patients, health reform of itself is not necessarily a good thing. Negative media attention to failed health reform agendas is endemic in developed countries. Fiji's nurse leaders expressed confidence in health reform during the time of this study; the challenge for them will be to provide appropriate leadership as part of a multidisciplinary team whatever the eventual outcomes of such reform. Nevertheless, multidisciplinary leadership was possible as women's role was changing in Fiji society and this is reflected in Jalal's (2002) comment that "women's skills should be better utilised" (p.25) in that country. She indicated that one of these skills might well be that women are more caring, because they are socialised to be so. This is fascinating, given an emerging literature concerning the need for nurse leaders to 'care' (Bondas, 2003; Cook & Leathard, 2004). 'Being caring' for the participants did not mean being disempowered. Rather, this could be equated with the Fijian tradition of expressing *loloma* for others. Their intention to take a lead in health care, to be the sort of transformational leaders (Bass & Avolio, 1994) who would take Fiji forward was in some ways then a return to tradition. This tradition, nevertheless, would be restructured in the contemporary environment which is Fiji in the 21st century.

Habermas would contend that empowerment for these nurse leaders indicated a movement toward an ideal speech situation, where all could take an equal part in healthy debate about the Fiji health system. Inclusion of the community of patients in this discourse was something the nurse leaders viewed as further strengthening their own sense of power, as the intention was that all stakeholders would be able to engage in the discussion.

On becoming reflective

The aim of a critical study such as this is to engage with participants in a process of *praxis*, which involves enhanced reflection upon a situation in order to take action to change it for the better. There was a strong inference, both during interviews and in

more informal settings over the four years of interaction I had with participants during the time of the study, that they sensed their willingness and ability to reflect upon their situation had been significantly enhanced and this was mirrored by my own experiences as researcher. Health reform, including the clinical governance framework, had been processes that served to assist with such reflection. Comments concerning their desire for the nurses to 'challenge in a constructive manner' and 'we would like to ask our young nurses "what do you think"' were instructive. The nurse leaders sensed that increased thinking was empowering, reflection was empowering and our journey together was one of recognizing the social constructedness of health care systems. This assisted us to understand that it was possible therefore to reconstruct them. The notion of *praxis* proved significant from Habermas's theoretical perspective, where the aim was in part to recognize those elements of system which had been or could continue to be problematic in terms of the lifeworld of Fiji. The nurse leaders clearly recognized and spoke of the effects of British colonization for the nation and for nursing in Fiji. Together, we were essentially engaged in a postcolonial project where, for me, coming to appreciate the relevance of postcolonialism within this research process was a colossal development in my understanding of the world.

Young (2003, p.1) has suggested that "there are two kinds of white people: those who have never found themselves in a situation where the majority of people around them are not white and those who have been the only white person in the room". He further notes that being the minority person can mean that one is not authorized to do the talking in that situation. For me as researcher and as one who had been a nurse leader as part of my professional career, often being the only *kai valagi* in a room full of Fijian health professionals has been a humbling experience. The temptation to make the Other 'exotic' was there, but interacting over years with fellow nurse leaders, albeit people from a different country, and prolonged reflection about the significance of colonization and about my being from the dominant West, proved extremely useful in avoiding such labelling. Rather, we took the research journey together as a community of equals; certainly I retained the responsibility to, as de Laine (2000) suggests, consider the situation from the participants' perspective in order to learn what was going on in the Fiji Ministry of Health, but also to be an 'outsider' in order to better analyse and discuss the data. Nevertheless, all of us who were participating

in the system of the Ministry were part of the social scene being studied, and as referred to earlier, all had an impact upon what happened there. As one of the participants said: '*I look through life, I look back and [ask myself] what have I done…not for me, but for nursing'*. The intention with this research was to do something for nursing in Fiji. Maybe we have.

Summary

Carspecken (1996) contends that any society is a complex set of intersecting factors. This discussion has emphasised the major issues arising from the study, with the clear implication that the Fiji Ministry of Health is part of both the wider society of Fiji and of international health care. The nurse leaders in Fiji are not only members of the nursing profession in that country, but are subject to those same enabling and inhibiting factors affecting nurses around the world. They spoke of what it meant to be a nurse leader in Fiji and were observed in their roles at differing points along a continuum of being empowered to disempowered, during the time of the research. Their participation in a transformative praxis (Kincheloe & McLaren, 2003) leading to increased empowerment for themselves, the front-line nurses of Fiji and the patients has been explored, with reference to those factors which continue to restrain societal change towards overcoming oppressive forces. The empirical finding that they were 'finding their voices' within the Ministry occurred against a background inclusive of Fiji's independence as a nation and a changing discourse which created new roles for women, while continuing to celebrate traditional ones. These binary forces served to create tensions for the participants, where the reality of presenting at national health forums, participating in multidisciplinary education with medical doctors and challenging the tradition of respect for older age was woven through a tapestry of Fiji tradition which supported the place of Fiji women and nurses as subservient. Their contention that 'locals' should take decision-making roles in the country occurred in conjunction with continuing Western influence on the health care system. Such claims have been considered in terms of Carspecken's (1996) notion about whether claims will or will not 'catch on' in a given situation and it has been suggested that the sort of decisions locals make will have an impact on the sustainability of local power.

The findings that participants could 'legitimize their roles as the facilitators of best patient outcomes' and 'recognize their capacity to take a leading role in health care' was reflective of a move away from, as Habermas (1984, cited in Alvesson & Deetz, 2000) would contend, traditional cultural values that were insufficiently reflected upon. Reflection upon the difficult conditions within which front-line nurses worked in Fiji and the nurse leaders own distance from such conditions, created the possibility for change for the better. A changing role for nurse leaders was also reflective of an evolving discourse in Fiji about what it meant to be a good citizen (Connell, 2007) where the good citizen is a 'modern' citizen, thus the issue of the socially constructed 'modern effective nurse leader' has been explored. This notion of modernity encompasses the nurse leaders' increasing focus on patient safety and customer focus and is reflective of a changing international discourse in this direction. The challenge of participating in such dialogue in a developing country has been highlighted, inclusive of problems with basic resources, migration of nurses out of the country and the threat of unfulfilled promises associated with health reform, such as the introduction of the clinical governance framework. The latter is of particular relevance internationally, as health departments make commitments about the outcomes of health reform which then fall short of expectations. The mood in the Fiji Ministry of Health during the time of this study was, nevertheless, optimistic about what was possible in terms of an enhanced role for nurse leaders encompassing more effective leadership, better nursing care, and improved patient care. The role of the nurse leader in Fiji continues to be constructed from an historical, cultural and social perspective (Schwandt, 2003) and this is reflective of nursing internationally, where nurses strive to make a place in health care systems which will benefit both themselves and the wider community.

Conclusion

This chapter has involved a discussion about the findings that emerged from this study and has extended the understanding gained from earlier chapters by further comparison with the existing literature concerning nursing leadership and clinical governance, with a particular focus on the situation in Fiji. In the next chapter, which is the final chapter for this thesis, this discussion will be linked with recommendations for health care practice, for education and for further research, as well as strengths and limitations of the study and an overview of the researcher role.

Chapter 8

The Conclusion

"Can you teach me to fly like that?" Jonathan Seagull
trembled to conquer another unknown.
"Of course, if you wish to learn."
"I wish. When can we start?"
"We could start now, if you'd like."
"I want to learn to fly like that," Jonathan said, and
a strange light glowed in his eyes. "Tell me what to do."
Chiang spoke slowly and watched the younger gull
ever so carefully. "To fly as fast as thought, to anywhere that
is," he said, "you must begin by knowing that you have already arrived".
(Bach, 1970, p.58)

I wrote in the Introduction to this thesis that health reform is about providing decent and safe health care to communities. In this conclusion, which is the final chapter for the thesis, I discuss how this study can contribute to that aim both in Fiji and internationally. Recommendations will be made which are intended to impact upon health care policy, nursing leadership, education, nursing practice and consequently the delivery of safe and effective care to patients. The recommendations are based upon findings in this study, which were arrived at from a critical Habermasian reading of interview texts and the review of multiple documents that influenced health care policy and practice in Fiji. This occurred as well as informal conversations with and observations of Fiji Ministry of Health personnel and patients as they lived their daily lives during the years 2004 – 2007. Carspecken's methodology and the Habermasian lens informed a thesis in which I have argued that nursing leadership occurs within oppressive organizational structures but that it is possible, through reflection and action, to overcome elements of oppression for the good of a whole society. The intention of this study was for participants to proactively choose thinking and behaviour leading to effective nursing leadership while moving away from, as we all must, "the efficient pursuit of goals that we never debated [and which become] the point of our lives" (Hanks, 2002, p.84). The critical lens has enabled me, through this study, to provide a comprehensive discussion and explanation of nursing leadership, nursing practice and patient care in the Fiji Islands and thus contribute

groundbreaking knowledge to health care in the Western Pacific and to developing countries worldwide. It must also be noted once again that postcolonial theory influenced this study and any recommendations are made with the intent to avoid a "universalising tendency inherent in Western knowledge systems" (Westwood, 2006, p. 98). This alludes to the tendency for Western science to be promoted internationally at the expense of other 'non-Western' systems. In saying this, I remain aware of the danger of dismissing the voice of the subaltern (Bhabha, 1994; Racine, 2002; Cooper, 2003; Betts, 2004) when making my own recommendations. It should be clear, however, from a reading of this thesis, that recommendations are reflective of the voices of the participants.

This conclusion also outlines the strengths of this research as well as the limitations and provides suggestions for potential future research, which will further inform the phenomenon of health care planning, delivery and evaluation in the Fiji Islands and elsewhere. Finally, I further reflect upon my own role as researcher and discuss how that has influenced the research process and this thesis.

Recommendations

In reconstructing the tapestry of how nursing leadership, nursing practice, patient care and indeed all of health care planning, delivery and evaluation could look like in Fiji, these recommendations form the threads of a health community resembling that of Habermas's 'unrestricted communication community' (Edgar, 2006). I have endorsed, throughout this thesis, the possibility of a community of health professionals who are appropriately educated, technically skilled and motivated toward the good of each other and of the patients who are the recipients of their care. Acting upon the following recommendations would be a way forward to achieving such a community.

Recommendations for health policy

- That international aid agency staff receive education regarding postcolonialism, inclusive of the practical application of equitable relationships with local personnel.

International aid agency staff involved in the Fiji Ministry of Health Improvement Program were, at the time of this study, generally culturally sensitive and of good intention concerning assisting local health professionals to improve health services. In such an environment, nevertheless, the possibility for inadvertently reinforcing the colonial project always exists. My own insights regarding postcolonialism, which occurred as a component of this study, were invaluable in enabling me to resist the temptation to consider dominant Western thinking and ways of planning for, implementing and managing health care as superior. International aid agency staff should receive the same benefits and the preferred option would be for locals and foreigners to participate in shared education about postcolonialism/decolonization so that such knowledge can be applied by people working together in a developing country.

- That nurse leaders of the Western Pacific ensure they have comprehensive involvement in World Health Organization planning for overcoming the problem of nurse migration out of their region.

As previously stated, The Pacific Islands Forum Secretariat is in the process of formulating a Pacific Code of Practice for the Recruitment of Health Personnel within the Pacific Region (World Health Organization, 2006c). Nurse leaders of the region are best positioned to identify those aspects of nursing conditions which contribute to nurses leaving developing countries and those which would encourage them to stay. Their involvement in formulating the Code of Practice would serve to strengthen the Code in ways that could result in real gains in the retention of nurses across the region.

- That nurse leaders in Fiji be formally chosen with regard to their talent and commitment to a particular role, regardless of age, ethnicity or chiefly status, through a specific recruitment and selection process.

The nurse leaders of Fiji specifically stated their concern about nurses having to wait until relative middle-age before achieving leadership positions. This current system, along with obvious disadvantages to potential Indo-Fijian nurse leaders in the country

and a long history of sometimes choosing leaders because of their chiefly status rather than capacity for leadership, continues to influence the way nursing leadership occurs. This is a particularly fraught issue from a postcolonial perspective, as respect for the wisdom of elders is an integral component of Fiji culture. Celebration of youth over age has connotations of a particularly Anglo-American approach that possibly expresses "a neo-imperialist disregard for the independence and autonomy of the Third World" (Bhabha, 2004, p.20). Thus I make this recommendation tentatively but with respect to the voices of the participants in this study. Therefore, although this would constitute a break with tradition, the nurse leaders are saying that they want this change, that is, they want nurses chosen for leadership based upon talent and commitment to the leadership role as they believe this would significantly benefit the health system throughout Fiji.

Recommendations for nursing leadership

- That nurse leaders internationally regularly undertake rigorous and formal reflection upon the social constructedness of their roles within particular organizations to avoid 'automatic' oppressive behaviour towards front-line nurses and patients.

- That nurse leaders pursue direct, formal, regular mechanisms for dialogue with front-line nurses to gain an optimum understanding of the conditions within which nurses undertake their daily work.

- That nurse leaders pursue direct, formal, regular mechanisms for dialogue with consumers to gain an enhanced understanding of the patient perspective on nursing care.

- That feedback from front-line nurses and patients become integral to future planning, implementation and evaluation of nursing conditions and nursing practice.

- That nurse leaders in the Western Pacific include discussion of reflective processes, nursing conditions and consumer involvement at both formal and informal gatherings to further the patient safety agenda in the region.

Within any organisation, the social constructedness of roles is inclusive of reinforcing institutionalized discourse in such a way that dominant voices are heard at the expense of the advantage of healthy debate where all are able to have input into the organisation. Reflection about such processes by nurse leaders increases the possibility of an organisation functioning closer to the ideal of Habermas's 'unrestricted communication community' (Edgar, 2006) rather than as one where system has destructively colonized lifeworld. An enhanced understanding of such processes would contribute to nurse leaders seeking opinion from all stakeholders and utilising such knowledge to contribute to a better health service.

- That nurse leaders internationally pursue regular, formal 'protected time' for continuing education concerning the relationship between effective nursing leadership, nursing conditions and patient safety.

- That education concerning transformational nursing leadership be undertaken by existing and prospective nurse leaders.

The literature concerning 'protected time' for leadership education is compelling both as it relates to clinical governance and to educating for personal leadership effectiveness. Despite concerns about a 'Western' paradigm associated with theory around transformational leadership, the nurse leaders of Fiji saw taking elements of the West and applying them locally as useful. Nevertheless, Westwood's (2006) concerns are relevant here concerning the necessity to promote variance and diversity in leadership, rather than assuming a North American notion of transformational leadership be adopted unquestioned. Rather, the recommendation concerns the possibility of taking those elements of the West that best suit Fiji and adapting them to local needs. Again, 'protected time' can only serve to better prepare nurse leaders for their challenging roles.

- That consideration of the individual nurse's personal and social circumstances be considered, while not contravening privacy laws, as a component of nursing conditions.

Nursing conditions generally constitute those aspects of working life that either inhibit or enable the delivery of effective nursing care. Obviously nurse staffing, work hours, the complexity of nursing work, infrastructure and other aspects of the physical environment, teamwork and attitudes of others towards mistakes are crucial elements of nursing conditions. In Fiji, I found that a nurse's personal circumstances also affected the ability to function in the workplace, particularly where home life was challenging and contributed to absenteeism and other problems associated with the delivery of nursing care. Consideration of such circumstances would result in a crucial element of nursing conditions being considered rather than ignored in terms of retaining a skilled nursing workforce.

Recommendations for education

- That health education institutions internationally plan for and pursue multidisciplinary education, where appropriate, at the undergraduate and postgraduate levels of formal education programmes.

- That health departments internationally plan for and pursue multidisciplinary continuing education, where appropriate, particularly regarding leadership and management, health reform and change management.

- That consumer representation be included in both formal and continuing health education, health reform activities and change management.

- That local consumer education, in a form most suitable for particular consumer groups, be provided to ensure optimum consumer involvement in health care planning, delivery and evaluation.

Traditionally, health education has been delivered separately to health professionals and the patient, as a component of the health education process, largely ignored. The clinical governance literature is extremely persuasive in advocating for a

multidisciplinary approach (inclusive of the patient) to all health care activities. The nurse leaders of Fiji saw multidisciplinary education as a vehicle for their own empowerment. Education programs involving not only health professionals but also patients would be an undeniable step forward in terms of more effective delivery of health care and the safer provision of care to patients.

Recommendations for front-line nurses/nursing practice

- That front-line nurses make the patient and patient safety the central tenet of all of their nursing practice.

- That nurses ask for patient feedback about practice and incorporate such feedback into their everyday nursing activities.

- That nurses communicate to nurse leaders their opinion about the strengths and limitations of the conditions within which they work.

- That nurses clearly articulate those issues that would cause them to either migrate out of their home country or that would contribute to them remaining at home to contribute to effective nursing practice.

Front-line nurses deliver the care to patients. Whatever nurse leaders and other health care planners decide should be done is either successful or otherwise depending upon the activities that actually occur in everyday practice across community settings or within hospitals around the world. The front-line nurses of Fiji have been traditionally a somewhat passive group who undertake their practice in challenging conditions. They often migrate to developed countries for reasons associated with such conditions and because they are unable to fulfil their goals of providing excellent care to patients. Empowerment for this group would constitute a situation where they are able to discuss their difficulties with those who have the ability to change them. In so doing, empowerment for the front-line nurses could significantly advance the patient safety agenda in the region.

Strengths of the research

The particular strength of this study was its groundbreaking position concerning allowing the voices of the nurse leaders of Fiji to be heard. Formal research about nursing in Fiji has thus far been limited to Leckie's (2000) inclusion of nurses into her work with women in Fiji, Brown and Connell's (2006) review of nurse migration and Usher and Lindsay's (2003/2004) study of nurse practitioners. By linking the international literature concerning nursing leadership, nursing conditions/migration and patient safety to the situation in Fiji, this study provides the first comprehensive study of nursing throughout the Western Pacific. In so doing, it provides direction for future research which will give further impetus to the patient safety agenda throughout the region.

The critical approach used in the study enhances the strength of the findings by contextualizing Fiji's postcolonial situation in ways that reveal continuing oppression from within the Ministry and externally. This has enabled the inclusion of findings which will serve to emancipate both staff and patients of the Ministry, leading to more effective nursing care and safe, optimum patient experiences. The study adds significantly to the literature concerning nursing leadership and clinical governance by contextualizing these processes to the situation of a developing country, giving voice to nurse leaders, nurses and patients who experience health care outside the dominant, rich, Western environment. It sets the path for future research in this area throughout the Western Pacific and in other developing countries. In this way a body of literature which will best guide nursing leadership, nursing practice and safer patient experiences globally, rather than more often in developed countries such as the United States, Canada, the United Kingdom, Europe, Australia and others.

Limitations of the research

A limitation of this study concerns the ethnicity of all of the senior nurse leaders in Fiji at the time of this study. All were indigenous Fijians and beyond informal interaction with and observation of Indo-Fijian nurses, the voices of potential Indo-Fijian nurse leaders were not present in this study. This provides direction for future research, as will be mentioned, in a country where almost half of the population is Indo-Fijian. In addition, the voices of front-line nurses and patients is largely absent because although I had informal interaction with both and observed them during the

study, they were not interviewed regarding their experiences of clinical governance. Again, this paves the way for further research regarding nurses and patients in Fiji. Finally, the problem of any research involving interviews with participants, where the possibility exists concerning the sincerity of stories was present. While engaging in all possible ways to overcome this, I remained aware that as not only a researcher, but also as a health consultant who had been involved with them in introducing clinical governance, I had to continue to match the participants' stories with what I saw happening in Fiji. As has been suggested, I believe I largely achieved this.

Future research

Future directions for research about nursing leadership, nursing practice and patient care within a clinical governance framework have been alluded to. I recommend that:

- Qualitative exploration of the experiences of nurse leaders of the Western Pacific be undertaken to provide further understanding of the place of nurse leaders throughout the region, in order to contribute to enhanced nursing leadership not only in Fiji but across the Pacific.
- Qualitative exploration of the experiences of front-line nurses in Fiji and elsewhere in the Western Pacific be undertaken as part of health reform processes, as this would further the understanding of necessary changes in both urban and rural health facilities throughout the region.
- Studies of the patient experience in Fiji and elsewhere in the Western Pacific, using mixed methods approaches, be undertaken to address the diverse experiences and outcomes for patients in primary health care, acute hospital care and rehabilitative care situations. A mixed methods approach would be appropriate as demographics, patient perspectives and morbidity and mortality data would provide a comprehensive picture of patient experiences in the region. Findings could then be utilized to further the patient safety agenda.

My role as researcher – final reflections

I have commented that this research is research for the people of Fiji and for me. I ponder my own journey over the past several years and have returned to my reflective journal and 'research notebook' continuously throughout the journey. As I write these words in 2007, surrounded by drafts of this thesis, journal articles, newspaper

clippings, organisational reports, textbooks and folders filled with my jottings I continue to compare the last several years with Jonathan Livingston Seagull's learning to fly in new ways. I will never be the same again. Becoming a critical theorist has changed the ways in which I relate to my world. As Thomas (1993, p.2) asked: "why should we be content to understand the world instead of trying to change it?" What does 'changing the world' mean, however? Does it indicate arrogance where the critical theorist thinks he or she knows better than others how their world should be? Or is it indicative of sharing, where knowledge gained equates with a mutual transformation of particular circumstances? Certainly the latter, where my reflective journal entries include this one from August of 2005:

> *Setting forth today to try and interview the first participants for my research study. I'm nervous, very aware of the issues surrounding 'power' this morning, very aware of working as a community of equals.*

Kincheloe and McLaren (2003, p.437) warn critical researchers of "the arrogance that may accompany efforts to emancipate 'others'" and the aim of this research has consistently been that of Habermas's idea of an 'unrestricted communication community' (Edgar, 2006) where my role and that of participants has been about the sharing of experiences leading to new knowledge and the possibility of emancipation from oppressive organisational forces.

The key issue here is about the transformations that characterize not only participants but also researcher during the process of critical research. My previous experiences as a nursing administrator in a large tertiary teaching hospital came with sometimes unreflective movements towards the 'taking on' of oppressive organisational values in my everyday life as nurse leader and manager. My experience as a critical nurse researcher came with an increased recognition that this had occurred and that it was possible for all of us who function as nurse leaders to share this increased reflexivity.
It would be remiss of me to not also note the challenges associated with completing this thesis. A May 2006 entry from my reflective journal:

> *Finally finished transcribing the interviews last night. Wow! What a long 'keep your bum on the seat until you're finished' process. At times, listening to the audiotapes, I became so excited about something that had happened in the conversation – at other times it just felt laborious and I couldn't wait to get done so I could really start reviewing and analysing what we'd said;*

Another from February of 2007:

> *Have hundreds of little notes everywhere as well as this journal – at least I've kept them. My reflections as I work to analyse – mostly how to ensure the participants' voices are being heard, rather than mine. I travel through the transcripts over and over again – is this what she meant? How can I read this better? Paralysed with fear at times, that I'm getting it 'wrong'. Reading and reading Habermas and Carspecken – will I ever know enough? Every time I read I learn more. How much time do I spend reading, how much writing. Oh, the pain of it all!*

Finally, from March of 2007:

> *My life is measured in words; I'm measuring my life in words. 2,000 words is a good day, less than that a troublesome, challenging day. My success with this consists of getting up, sitting at my desk (still in my old blue dressing gown), at the computer, with that goal of 2,000 words the focus for my day. Write, get up, sit down, read, write, drink a coffee sometime in the morning, read, write, play 'head games' with myself to keep going ('count the words')…the key is 'starting it' and 'make myself keep doing it'. Ah, SSP – measured in words.*

So critical research is about my philosophical approach to the world and it is also about the tedium and glory of the logistics around completing a piece of work. Again I cannot help but compare this journey with the little seagull Jonathan learning to fly in new and liberating ways. As Jonathan Livingston Seagull's protégée Fletcher Seagull found after the departure of his mentor:

After a time, Fletcher Gull dragged himself into the sky and faced a brand-new group of students, eager for their first lesson.

"To begin with," he said heavily, "you've got to understand that a seagull is an unlimited idea of freedom, an image of the Great Gull, and your whole body, from wingtip to wingtip, is nothing more than your thought itself."

The young gulls looked at him quizzically. Come on, they thought, this doesn't sound like a rule for a loop.

Fletcher sighed and started over. "Hm. Ah…very well," he said, and eyed them critically. "Let's begin with Level Flight." And saying that, he understood all at once that his friend had quite honestly been no more divine than Fletcher himself.

No limits, Jonathan? he thought. Well, then, the time's not distant when I'm going to appear out of thin air on your beach, and show you a thing or two about flying!

And though he tried to look properly severe for his students, Fletcher Seagull suddenly saw them as they really were, just for a moment, and he more than liked, he loved what it was he saw. No limits, Jonathan? he thought, and he smiled. His race to learn had begun. (Bach, 1970, p.93)

References

Aiken, L. H. (2001). More nurses, better patient outcomes: why isn't it obvious? *Effective Clinical Practice, 4*(5), 223-225.

Aiken, L. H. (2006). Effects of workplace environments for hospital nurses on patient outcomes. In G. Lobiondo-Wood & J. Haber (Eds.), *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice*. St Louis: Mosby.

Aiken, L. H., Buchan, J., Sochalski, J., Nichols, B., & Powell, M. (2004). Trends in international nurse migration. *Health Affairs, 23*(3), 69 - 77.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., Busse, R., Clarke, H., et al. (2001). Nurses' reports on hospital care in five countries. *Health Affairs, 20*(3), 43 - 53.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout and job dissatisfaction. *Journal of the American Medical Association, 288*(16), 1987-1993.

Alarcon, A. M., Astudillo, P. R., Barrios, S. A., & Rivas, E. E. (2002). Nursing leadership in Chile: a concept in transition. *Nursing Science Quarterly, 15*(4), 336 - 341.

Alvesson, M. (1996). *Communication, Power and Organization*. Berlin: Walter de Gruyter & Co.

Alvesson, M., & Deetz, S. (2000). *Doing Critical Management Research*. London: Sage Publications Ltd.

Alvesson, M., & Skoldberg, K. (2000). *Reflexive Methodology*. London: Sage Publications.

Alvesson, M., & Willmott, H. (1992). On the idea of emancipation in management and organization studies. *The Academy of Management Review, 17*(3), 432 - 464.

Anon. (2001). Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 - 1995. Retrieved January 6, 2005, from www.bristol.inquiry.org.uk/.

Anon. (2007, March 8). Roles women play. *Fiji Times Online.* Retrieved March 8 2007, from http://www.fijitimes.com.story/

Ashcroft, B. (2001). *On Post-colonial Futures.* London and New York: Continuum

Ashcroft, B., Griffiths, G., & Tiffin, H. (2002). *The Empire Writes Back: theory and practice in post-colonial literature* (2nd ed.). London and New York: Routledge Taylor & Francis Group.

Avolio, B. J. (2007). Promoting more integrative strategies for leadership theory-building. *American Psychologist, 62*(1), 25-33.

Bach, R. (1972). *Jonathan Livingston Seagull*. London: Pan Books Ltd.

Baillie, L., Bassett-Smith, J., & Broughton, S. (2000). Using communicative action in the primary prevention of cancer. *Health Education & Behavior, 27*(4), 442 - 453.

Balding, C. (2005). Strenghthening clinical governance through cultivating the line management role. *Australian Health Review, 29*(3), 353-359.

Barry, C. A., Stevenson, F. A., Britten, N., Barber, N., & Bradley, C. P. (2001). Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor-patient communication in general practice. *Social Science & Medicine, 53*(4), 487 - 505.

Bass, B., & Avolio, B. (1994). *Improving Organisational Effectiveness*. Thousand Oaks: Sage.

Bass, B. M. (1985). *Leadership and performance beyond expectations*. New York: Free Press.

Bayliss, P., Hill, P., Calman, K., & Hamilton, J. (2001). Education for clinical governance. *British Journal of Clinical Governance, 6*(1), 7-8.

Bennis, W. (1989). *On Becoming A Leader*. Reading, Massachusetts: Addison-Wesley Publishing Company.

Bhabha, H.K. (1994). *The Location of Culture*. London and New York: Routledge.

Blunt, P., & Jones, M. L. (1997). Exploring the limits of Western leadership theory in East Asia and Africa. *Personnel Review, 26*(1/2), 6-23.

Boggust, M., Deighan, M., Cullen, R., & Halligan, A. (2002). Developing strategic leadership of clinical governance through a program for NHS boards. *British Journal of Clinical Governance, 7*(3), 215-217.

Bondas, T. E. (2003). Caritative leadership: ministering to the patients. *Nursing Administration Quarterly, 27*(3), 249-253.

Brison, K. J. (2003). Imagining modernity in rural Fiji. *Ethnology, 42*(4), 335 - 348.

Brown, R. P. C., & Connell, J. (2006). Occupation-specific analysis of migration and remittance behaviour: Pacific Island nurses in Australia and New Zealand. *Asia Pacific Viewpoint, 47*(1), 135 - 150.

Buchan, J. (1999). The 'greying' of the United Kingdom nursing workforce: implications for employment policy and practice. *Journal of Advanced Nursing, 30*(4), 818-826.

Cameron, A., & Masterson, A. (2000). Managing the unmanageable? Nurse executive directors and new role developments in nursing. *Journal of Advanced Nursing, 31*(5), 1081 - 1088.

Campbell, S. (2004). A first world service? *Primary Health Care, 14*(5), 38 - 40.

Caraminca, L., Cousino, J. A., & Peterson, S. (2003). Four elements of a successful quality program: alignment, collaboration, evidence-based practice and excellence. *Nursing Administration Quarterly, 27*(4), 336-343.

Carspecken, P. F. (1996). *Critical Ethnography in Educational Research*. New York and London: Routledge.

Carspecken, P. F., & Cordeiro, P. A. (1995). Being, doing and becoming: textual intepretations of social identity and a case study. *Qualitative Inquiry, 1*(1), 87 - 109.

Chan, S. (2002). Factors influencing nursing leadership effectiveness in Hong Kong. *Journal of Advanced Nursing, 38*(6), 615 - 623.

Christians, C. G. (2003). Ethics and politics in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Landscape of Qualitative Research: Theories and Issues* (2nd ed., pp. 208 - 243). Thousand Oaks, California: Sage Publications, Inc.

Clark, C. E., & Smith, L. F. P. (2002). Clinical governance and education: the views of clinical governance leads in the south west of England. *British Journal of Clinical Governance, 7*(4), 261-266.

Collier, J., & Esteban, R. (2000). Systemic leadership: ethical and effective. *The Leadership & Organization Development Journal, 21*(4), 207-215.

Comstock, D. E. (1982). A method for critical research. In F. Bredo & W. Feinberg (Eds.), *Knowledge and Values in Social and Educational Research*. Philadelphia: Temple University Press.

Connell, J. (2007). The Fiji Times and the good citizen: constructing modernity and nationhood in Fiji. *The Contemporary Pacific, 19*(1), 85-109.

Considine, J., & Botti, M. (2004). Who, when and where? Identification of patients at risk of an in-hospital event: implications for nursing practice. *International Journal of Nursing Practice, 10*, 21 - 31.

Cook, M. J. (2001). The renaissance of clinical leadership. *International Nursing Review, 48*, 38-46.

Cook, M. J., & Leathard, H. L. (2004). Learning for clinical leadership. *Journal of Nursing Management, 12*, 436-444.

Courtney, M., Nash, R., & Thornton, R. (2004). Leading and managing in nursing: concepts, processes and challenges. In J. Daly, S. Speedy & D. Jackson (Eds.), *Nursing Leadership* (pp. 1 - 18). Marrickville: Elsevier Australia.

Covey, S. R. (2004). *The 8th Habit*. New York: Free Press.

Creswell, J. (2003). *Research Design* (2nd ed.). Thousand Oaks: Sage Publications.

Crossley, N. (2005). *Key Concepts in Critical Social Theory*. London: Sage Publications.

Crowe, M. (1998). The power of the word: some post-structural considerations of qualitative approaches in nursing research. *Journal of Advanced Nursing,* 28, 339 – 344.

Crotty, M. (1998). *The Foundations of Social Research*. Crows Nest, NSW: Allen & Unwin.

Currie, L., & Loftus-Hill, A. (2002). The nursing view of clinical governance. *Nursing Standard, 16*(27), 40-44.

Daly, J., Speedy, S., & Jackson, D. (Eds.). (2004). *Nursing Leadership*. Sydney: Churchill Livingston.

Darby, D. N., & Daniel, K. (1999). Factors that influence nurses' customer orientation. *Journal of Nursing Management, 7*, 271-280.

Davies, G. (2005). Queensland public hospitals commission of inquiry report. Retrieved 26 January 2007, from http://www.qphci.qld.gov.au/Final_Report.htm

Davis, B. (2005). AusAID Annual Report 2004 - 2005. Retrieved 3 March 2007, from www.ausaid.gov.au/default.cfm

de Laine, M. (2000). *Fieldwork, Participation and Practice: Ethics and Dilemmas in Qualitative Research*. London: Sage Publications.

Degeling, P. J., Maxwell, S., Iedema, R., & Hunter, D. J. (2004). Making clinical governance work. *British Medical Journal, 329*, 679-681.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2003). *The Landscape of Qualitative Research* (2nd ed.). Thousand Oaks: Sage Publications.

Driu Fong, M. (2003). *Review of options for achieving an adequate and cost effective supply of appropriately qualified nurses for the Fiji health system*: Ministry of Health, Fiji.

Duckett, S. J. (2007). A new approach to clilnical governance in Queensland. *Australian Health Review, 31*(Suppl1), S16-S19.

Edgar, A. (2006). *Habermas: The Key Concepts*. London and New York: Routledge Taylor and Francis Group.

Edmonson, A. (2004). Learning from failure in health care: frequent opportunities, pervasive barriers. *Quality and Safety in Health Care, 13*(suppl II), ii3-ii9.

Elfering, A., Semmer, N. K., & Grebner, S. (2006). Work stress and patient safety: observer-rated work stressors as predictors of characteristics of safety-related events reported by young nurses. *Ergonomics, 49*(5-6), 457-469.

Fay, B. (1987). *Critical Social Science*. Ithaca, New York: Cornell University Press.

Fay, B. (1996). *Contemporary Philosophy of Social Science*. Malden, MA: Blackwell.

Fedoruk, M., & Pincombe, J. (2000). The nurse executive: challenges for the 21st century. *Journal of Nursing Management, 8*, 13 - 20.

Ferguson, B. (2002). Learning from Bristol: reflections from a health economist. *British Journal of Clinical governance, 7*(4), 233-241.

Fetterman, D. M. (1998). *Ethnography* (2nd ed.). Thousand Oaks: Sage Publications.

Fiedler, F. E. (1967). *A Theory of Leadership Effectiveness*. New York: McGraw-Hill.

Finlayson, J. G. (2005). *Habermas: A Very Short Introduction*. Oxford: Oxford University Press.

Firth-Cozens, J. (1999). Clinical governance development needs in health service staff. *British Journal of Clinical Governance, 4*(4), 128-134.

Fletcher, K. (2006). Beyond dualism: leading out of oppression. *Nursing Forum, 41*(2), 50 - 59.

Fontana, J. S. (2004). A methodology for critical science in nursing. *Advances in Nursing Science, 27*(2), 93 - 101.

Ford, D. (2006). Patient safety: the patient's role. *World Hospitals and Health Services, 42*(3), 45-48.

Forester, J. (1992). Critical ethnography: on fieldwork in a Habermasian Way. In M. Alvesson & H. Willmott (Eds.), *Critical Management Studies* (pp. 47 - 65). London: Sage.

Forester, J. (1993). *Critical Theory, Public Policy and Planning Practice*. Albany: State University of New York Press.

Foster, W. (1986). *The Reconstruction of Leadership*. Victoria: Deakin University Press.

Frankel, A. S., Leonard, M. W., & Denham, C. R. (2006). Fair and just culture, team behavior, and leadership engagement: the tools to achieve high reliability. *Health Research and Educational Trust, 41*(4), 1690 - 1709.

Franks, A. J. (2001). Clinical governance as a restructuring of quality assurance processes: the focus from corporate to clinical action. *British Journal of Clinical Governance, 6*(4), 259-263.

Freeman, T. (2003). Measuring progress in clinical governance: assessing the reliability and validity of the clinical governance climate questionnaire. *Health Services Management Research, 16*(4), 234-250.

Freire, P. (1999). *Pedagogy of the Oppressed*. New York: Continuum.

Gallagher, R. M., & Rowell, P. A. (2003). Claiming the future of nursing through through nursing-sensitive quality indicators. *Nursing Administration Quarterly, 27*(4), 273-284.

Gantz, N. R., Sorenson, L., & Howard, R. (2003). A collaborative perspective on nursing leadership in quality improvement: the foundation for outcomes management and patient/staff safety in health care environments. *Nursing Administration Quarterly, 27*(4), 324 - 329.

Georgiou, D., & Carspecken, P. F. (2002). Critical ethnography and ecological psychology: conceptual and empirical explorations of a synthesis. *Qualitative Inquiry, 8*(6), 688 - 706.

Ginsburg, L., Norton, P. G., Casebeer, A., & Lewis, S. (2005). An educational intervention to enhance nurse leaders' perceptions of patient safety culture. *Health Services Research, 40*(4), 997-1020.

Glesne, C., & Peshkin, A. (1992). *Becoming Qualitative Researchers*. White Plains, N.Y.: Longman.

Goleman, D., Boyatzis, R., & McKee, A. (2002). *The New Leaders: transforming the art of leadership into the science of results*. London: Little, Brown.

Gott, R. (2001). What can the Commonwealth learn from its history? [Electronic Version]. *The Round Table*, 362, 673-677. Retrieved February 7, 2005 from http://taylorandfrancis.metapress.com/media/.

Grainger, C., Hopkinson, R., Barrett, V., Campbell, C., Chittenden, S., Griffiths, R., et al. (2002). Implementing clinical governance - result of a year's programme of semi-structured vists to assess the development of clinical governance in the West Midlands Trust. *British Journal of Clinical Governance, 7*(3), 177-186.

Grbich, C. (2004). *New Approaches in Social Research*. London: Sage Publications.

Greenhalgh, T., Robb, N., & Scambler, G. (2006). Communicative and strategic action in interpreted consultations in primary health care: a Habermasian perspective. *Social Science & Medicine, 63*, 1170 - 1187.

Gregory, D. M., Guse, L. W., Davidson, D., & Russell, C. K. (2007). Patient safety: where is nursing education? *Journal of Nursing Education, 46*(2), 79-82.

Grundy, S. (1987). *Curriculum: product or praxis?* London: Falmer Press.

Gurdayal, M. (2005, August 6). Hospitals struggle to cope. *Fiji Daily Post,* p. 1.

Habermas, J. (1984). *The Theory of Communicative Action*. Boston: Beacon Press.

Hanks, J. C. (2002). *Refiguring Critical Theory: Jurgen Habermas and the Possibilities of Political Change*. Lanham, Maryland: University Press of America.

Hardcastle, M.-A. (2004). The dialectic of control: a critical ethnography of renal nurses' decision-making. Unpublished PhD: James Cook University, Townsville.

Hardcastle, M.-A., Usher, K., & Holmes, C. (2006). Carpsecken's five-stage critical qualitative research method: an application to nursing research. *Qualitative Health Research, 16*(1), 151 - 161.

Harvey, L. (1990). *Critical Social Research*. London: Allen & Unwin.

Heard, S. R., Fergie, C., McCready Hall, L., Schiller, G., & Aitken, M. (2001). Continuous quality improvement: educating towards a culture of clinical governance. *Quality in Health Care, 10*(4), 1-12.

Hedley, A., Fennell, S., Wall, D., & Cullen, R. (2003). People will support what they help to create: clinical governance large group work. *Clinical Governance: An International Journal, 8*(2), 174-179.

Henriksen, K., & Dayton, E. (2006). Organizational Silence and Hidden Threats to Patient Safety. *Health Services Research, 41*(4), 1539-1554.

Hermanns, H. (2004). Interviewing as an activity. In U. Flick, E. von Kardoff & I. Steinke (Eds.), *A Companion to Qualitative Research* (pp. 209-213). London: Sage Publications.

Hersey, P., & Blanchard, K. (1969). Life cycle of leadership. *Training and Development Journal, 23*, 26-34.

Holmes, C. (1992). The drama of nursing. *Journal of Advanced Nursing, 17*, 941-950.

Holmes, C., & Warelow, P. (2000). Nursing as normative praxis. *Nursing Inquiry, 7*, 175-181.

Horner, M. (1997). Leadership theory: past, present and future. *Team Performance Management, 3*(4), 270-287.

Huberman, A. M., & Miles, M. B. (1994). Data management and analysis methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 428-444). Thousand Oaks: Sage.

Huntington, A.D. & Gilmour, J.A. (2001). Re-thinking representations, re-writing nursing texts: possibilities through feminist and Foucauldian thought. *Journal of Advanced Nursing,* 35(6), 902 – 908.

Hyde, A., & Roche-Reid, B. (2004). Midwifery practice and the crisis of modernity: implications for the role of the midwife. *Social Science & Medicine, 58*, 2613 - 2623.

Hyrkas, K., Paunonen, M., & Laippala, P. (2000). Patient satisfaction and research related problems (part 1). Problems while using a questionnaire and the possibility to solve them by using different methods of analysis. *Journal of Nursing Management, 8*, 227-236.

Irurita, V. F. (1996). Optimizing: a leadership process for transforming mediocrity to excellence - a study of nursing leadership. In K. W. Perry (Ed.), *Leadership Research and Practice - Emerging Themes and New Challenges* (pp. 125-138). South Melbourne: Pitman Publishing.

Jack, G., & Westwood, R. (2006). Postcolonialism and the Politics of Qualitative Research in International Business. *Management International Review, 46*, 481-501.

Jalaal, I. (2002). Fiji's 2001 elections: rebuilding a fractured nation. In K. Gravelle (Ed.), *Good Governance in the South Pacific* (pp. 24-31). Suva: The University of the South Pacific.

Kalisch, B. J., & Aebersold, M. (2006). Overcoming Barriers to Patient Safety. *Nursing Economics, 24*(3), 143-155.

Kanter, R. M. (1993). *Men and Women of the Corporation*. New York: Basic Books.

Katz, R. (1999). *The Straight Path of the Spirit*. Rochester, Vermont: Park Street Press.

Kelly-Heidenthal, P. (2003). *Nursing Leadership and Management*. New York: Delmar Learning.

Kennedy, D. (2003). Imperial history and post-colonial theory. In J.D. Le Seur (Ed.), *The Decolonization Reader* (pp. 7-22). New York and London: Routledge.

Kincheloe,J. & McLaren, P. (1994). Rethinking critical theory and qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research (*pp. 138 – 157). Thousand Oaks, California: Sage Publications.

Kincheloe, J., & McLaren, P. (2003). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Landscape of Qualitative Research: Theories and Issues* (2nd ed., pp. 433 - 488). Thousand Oaks, California: Sage Publications.

Kirkham, S.R. & Anderson, J.M. (2001). Postcolonial nursing scholarship: from epistemology to method. *Advances in Nursing Science*, 25(1), 1-17.

Kitson, A. (2001). Nursing leadership: bringing caring back to the future. *Quality in Health Care, 10*(Suppl 11), 79 - 84.

Kouzes, J. M., & Posner, B. Z. (2002). *The Leadership Challenge* (3rd ed.). San Francisco: Jossey-Bass.

Kuhnert, K. (1994). Transforming leadership: developing people through delegation. In B. Bass & B. Avolio (Eds.), *Improving Organisational Effectiveness*. Thousand Oaks: Sage.

Langley, A. (2000). Emotional intelligence - a new evaluation for management development? *Career Development International, 5*(3), 177 - 183.

Laverack, G. (2003). Building capable communities: experiences in rural Fijian context. *Health Promotion International, 18*(2), 99-106.

Laverack, G., & Brown, K. M. (2003). Qualitative research in cross-cultural context: Fijian experiences. *Qualitative Health Research, 13*(3), 333-342.

Lavoie-Tremblay, M., O'Brien-Pallas, L., Viens, C., Hamelin Brabant, L., & Gelinas, C. (2006). Towards an integrated approach for the management of ageing nurses. *Journal of Nursing Management, 14*, 207-212.

Leckie, J. (2000). Women in post-coup Fiji: negotiating work through old and new realities. In A. Haroom Akram-Lodhi (Ed.), *Confronting Fiji Futures*. Australia: Asia Pacific Press.

Lewin, K. (1951). *Field theory in social sciences*. New York: Harper & Row.

Lewis, M., & Urmston, J. (2000). Flogging the dead horse: the myth of nursing empowerment? *Journal of Nursing Management, 8*, 209-213.

Lewis, S. A., Saunders, N., & Fenton, K. (2002). The magic matrix of clinical governance. *British Journal of Clinical Governance, 7*(3), 150-153.

Lin, L., & Liang, B. A. (2007). Addressing the nursing work environment to promote patient safety. *Nursing Forum, 42*(1), 20 - 30.

Maddock, A., Kralik, D., & Smith, J. (2006). Clinical Governance improvement initiatives in community nursing. *Clinical Governance: An International Journal, 11*(3), 198-212.

Madraiwiwi, R. J. (2002). Fiji's 2001 elections: our country at the crossroads. In K. Gravelle (Ed.), *Good Governance in the South Pacific* (pp. 7-15). Suva: The University of the South Pacific.

Manias, E. & Street, A. (2000). Possibilities for critical social theory and Foucault's work: a toolkit approach. *Nursing Inquiry, 7, 50 – 60.*

Marquis, B. L., & Huston, C. J. (2006). *Leadership Roles and Management Functions in Nursing: Theory and Application* (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

Marris, S. (2007, March 3-4). Fijian economy 'close to collapse'. *The Weekend Australian,* p. 2.

Martell, R. (1999). Nursing 'uniquely' placed to lead clinical governance. *Nursing Standard, 14*(7), 8.

McKinley, C., Fletcher, A., Biggins, A., McMurray, A., Birtwhistle, S., Gardiner, L., et al. (2007). Evidence-based management practice: reducing falls in hospital. *Collegian, 14*(2), 20 - 25.

McLaughlin, E. M. (1944). School for Nurses at Suva. *The American Journal of Nursing, 44*(12), 1121-1122.

McMurray, A. (2003). *Community Health and Wellness: A Sociological Approach* (2nd ed.). Sydney: Mosby Elsevier.

McPhee, M., Ellis, J., & Sanchez McCutcheon, A. (2006). Nurse Staffing and Patient Safety. *Canadian Nurse, 102*(8), 19-23.

McSherry, R., & Pearce, P. (2002). *Clinical Governance: A Guide to Implementation for Healthcare Professionals*. Oxford: Blackwell Science Ltd.

McSherry, R., & Pearce, P. (2007). *Clinical Governance: A Guide to Implementation for Healthcare Professionals* (2nd ed.). Oxford: Blackwell Publishing Ltd.

Meleis, A. & Lipson, J. (2004). Cross-cultural health and strategies to lead development of nursing practice. In J. Daly, S. Speedy & D. Jackson (Eds.), *Nursing Leadership* (pp. 69-88). Sydney: Churchill Livingston.

Memmi, A. (1974). *The Colonizer and the Colonized.* London: Earthscan Publications Ltd.

Merkens, H. (2004). Selection procedures, sampling, case construction. In U. Flick, E. Von Kardoff & I. Steinke (Eds.), *A Companion to Qualitative Research* (pp. 165 - 171). London: Sage Publications.

Metwally, N. (January, 2007). Perspective from Egypt [Electronic Version]. *Patients for Patient Safety News*, 5. Retrieved 11 February 2007 from www.who.int.entity/patientsafety/patients_for_patient/en.

Miller, A., & Chaboyer, W. (2006). Captain and champion: nurses' role in patient safety. *Nursing in Critical Care, 11*(6), 265-266.

Milne, P. (2005). Clinical Services Planning Framework: Ministry of Health, Fiji.

Minichello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). *In-Depth Interviewing*. Melbourne: Longman Cheshire.

Ministry of Health. Fiji. (2003). Corporate Plan - 2003.

Ministry of Health. Fiji. (2003). Strategic Plan 2003 - 2005.

Ministry of Health. Fiji. (2005). *Fiji Strategic Plan 2005 - 2008*. Retrieved January 7, 2005 from http://www.fiji.gov.fj/

Mishler, E. G. (1981). Viewpoint: critical perspectives on the biomedical model. In E. G. Mishler, L. R. Amarasingham, S. D. Osherson, S. T. Hauser, N. E. Waxler & R. Liem (Eds.), *Social contexts of health, illness and patient care* (pp. 1 - 23). Cambridge: Cambridge University Press.

Mohammed, S. A. (2006). Moving beyond the "exotic": applying postcolonial theory in health research [Electronic Version]. *Advances in Nursing Science*, 29. Retrieved 11 February 2007 from http://proquest.umi.com.elibrary.jcu.edu.aupqdweb.

Morrow, R. (1994). *Critical Theory and Methodology*. Thousands Oaks, California: Sage.

Murray, W. E., & Storey, D. (2003). Political conflict in postcolonial Oceania. *Asia Pacific Viewpoint, 44*(3), 213-224.

Nayacakalou, R. R. (1975). *Leadership in Fiji*. Melbourne: Oxford University Press.

Nicholls, S., Cullen, R., O'Neill, S., & Halligan, A. (2000). Clinical governance: its origins and foundations. *British Journal of Clinical Governance, 5*(3), 172-178.

Nilan, P., Cavu, P., Tagicakiverata, I., & Hazelman, E. (2006). White collar work: career ambitions of Fiji final year school students. *International Education Journal, 7*(7), 895 - 905.

O'Connor, K. (2003). *Report for the development of clinical services plan for the Ministry of Health Fiji*.

O'Neill, J. (1985). Decolonization and the ideal speech community: some issues in the theory and practice of communicative competence. In J. Forester (Ed.), *Critical Theory and Public Life* (pp. 57 - 76). Cambridge, Massachusetts and London: The Massachusetts Institute of Technology.

Outhwaite, W. (1994). *Habermas A Critical Introduction*. Stanford, California: Stanford University Press.

Ovretveit, J. (1999). Evaluation informed management and clinical governance. *British Journal of Clinical Governance, 4*(3).

Pacific Islands Forum Secretariat. (2005). The Pacific Plan for Strengthening Regional Cooperation and Integration. Retrieved 3 May, 2007, from www.pacificplan.org/

Palmer, I. & Dunford, R. (1996). Conflicting use of metaphors: reconceptualising their use in the field of organizational change. *Academy of Management Review,* 21(3), 691-717.

Pickering, S., & Thompson, J. (2003). *Clinical Governance and Best Value*. Edinburgh: Churchill Livingston.

Prewitt, V. (2003). Leadership development for learning organizations. *Leadership & Organization Development Journal, 24*(2), 58 - 61.

Priest, A. (2006). Patient safety requires responsibility and accountability. *Nursing BC, 38*(4), 13 - 15.

Qiliho, A. (2006, May 6). Type of leaders this land needs. *The Fiji Times,* p. 7.

Racine, L. (2003). Implementing a postcolonial feminist perspective in nursing research related to non-Western populations. *Nursing Inquiry,* 10(2), 91-102.

Rathert, C., & May, D. R. (2007). Health care environments, employee satisfaction, and patient safety: care provider perspectives [Electronic Version]. *Health Care Management Review*, 32, 1 - 17. Retrieved 1 February 2007 from http:proquest.umi.com.elibrary.jcu.edu.au/pqdweb.

Ray, L. J. (1993). *Rethinking Critical Theory: Emancipation in the Age of Global Social Movements*. London: Sage Publications.

Robertson, R. T., & Tamanisau, A. (1988). *Fiji: Shattered Coups*. Leichardt, N.S.W.: Pluto Press Australia Limited.

Rogers, A. E., Hwang, W.-T., Scott, L. D., Aiken, L. H., & Dinges, D. F. (2004). The working hours of hospital staff nurses and patient safety [Electronic Version]. *Health Affairs*, 23, 1 - 7. Retrieved 2 February 2007 from http:proquest.umi.com/pqdweb.

Rokotuivana, A. (1973). Introduction. In A. Rokotuivana, J. Dakuvula, W. Narsey, I. Howie, P. Annear, D. Mahoney, A. Fong, C. Slatter & B. Noone (Eds.), *Fiji: A Developing Australian Colony* (pp. 4-9). North Fitzroy, Victoria: I.D.A.

Ross, S. J., Polsky, D., & Sochalski, J. (2005). Nursing shortages and international nurse migration. *International Nursing Review, 52*, 253 - 262.

Rozell, E. J., Pettijohn, C. E., & Parker, R. S. (2002). An empirical evaluation of emotional intelligence: the impact on management development. *Journal of Management Development, 21*(4), 272 - 289.

Said, E. (1978). *Orientalism: Western Conceptions of the Orient*. London: Penguin.

Sale, D. (2005). *Understanding Clinical Governance and Quality Assurance: Making It Happen*. Hampshire: Palgrave Macmillian.

Sanderson, H. (2000). Information requirements for clinical governance. *British Journal of Clinical Governance, 5*(1), 52-57.

Scally, G., & Donaldson, L. J. (1998). Clinical governance and the drive for quality improvement in the new NHS in England. *British Medical Journal, 317*, 61-65.

Scambler, G. (1987). Habermas and the power of medical expertise. In G. Scambler (Ed.), *Sociological Theory and Medical Sociology* (pp. 165-193). London: Tavistock.

Schwandt, T. A. (2003). Three Epistemological Stances for Qualitative Inquiry: Interpretivism, Hermeneutics, and Social Comparison. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Landscape of Qualitative Research* (2nd ed., pp. 292 - 331). Thousand Oaks: Sage Publications.

Scott, L. D., Rogers, A. E., Hwang, W.-T., & Zhang, Y. (2006). Effects of critical care nurses' work hours on vigilance and patients' safety. *American Journal of Critical Care, 15*(1), 30-37.

Senge, P. (1999). *The Fifth Discipline*. Milsons Point: Random House.

Serelini, K. (2007, 22 January 2007). Nurse leaves behind legacy. *Fiji Sun,* p. 8.

Sharpham, J. (2000). *Rabuka of Fiji*. Rockhampton: Central Queensland University Press.

Sheahan, M., Duke, M., & Nugent, P. (2007). Leadership in nursing. *Australian Nursing Journal, 14*(7), 28.

Sheps, S. (2006). New frontiers and approaches to clinical governance. *Clinical Governance: An International Journal, 11*(2), 141-147.

Shirey, M. R. (2004). Social support in the workplace: nurse leader implications. *Nursing Economics, 22*(6), 313 - 319.

Singh, M. (2007). 'Nightingale' calls it a day [Electronic Version]. *The Fiji Times*. Retrieved 29 January 2007 from http://www.fijitimes.com/story.

Slater, P. (1977). *Origin and significance of the Frankfurt School*. London: Routledge & Kegan Paul Ltd.

Smetzer, J., & Navarra, M. B. (2007). Measuring change: a key component of building a culture of safety. (patient safety). *Nursing Economics, 25*(1), 49-51.

Smyth, W., & Holmes, C. (2005). Using Carspecken's critical ethnography in nursing research. *Contemporary Nurse, 19*(1), 65 - 74.

Sofarelli, D., & Brown, D. (1998). The need for nursing leadership in uncertain times. *Journal of Nursing Management, 6*, 201 - 207.

Sosik, J. J., & Megerian, L. E. (1999). Understanding leader emotional intelligence and performance. *Group & Organization Management, 24*(3), 367 - 390.

Spilsbury, K., & Meyer, J. (2001). Defining the nursing contribution to patient outcomes: lessons from a review of the literature examining nursing outcomes, skill mix and changing roles. *Journal of Clinical Nursing, 10*, 3-14.

Spivak, G. (1987). *In Other Worlds: Essays in Cultural Politics*. New York: Methuen.

Squire, S., Greco, M., O'Hagan, B., Dickinson, K., & Wall, D. (2006). Being patient-centred: creating health care for our grandchildren. *Clinical Governance: An International Journal, 11*(1), 8-16.

Srivastva, S. & Barrett, F.J. (1988). The transforming nature of change in group development: a study in group theory. *Human Relations,* 41, 31 – 64.

Stewart, L. (2004). *Developing a framework for the development of standards in the Fiji Health System review process*: Ministry of Health, Fiji.

Stewart, L. (2004). *Fiji Health Sector Improvement Program - clinical governance/quality framework report*: Ministry of Health, Fiji.

Stewart, L. (2006a). *Fiji Health Sector Improvement Program - Report from the clinical governance short-term adviser (STA)*: Ministry of Health, Fiji.

Stewart, L. (2006b). The nurse as consultant. *Connections: Royal College of Nursing, Australia Newsletter, 9*(1), 17.

Stewart, L., Hanson, J., & Usher, K. (2006). Evidence-based management in clinical governance. *Collegian, 13*(4), 12 - 15.

Stewart, L. & Usher, K. (2007). Carspecken's critical approach as a way to explore nursing leadership issues. *Qualitative Health Research – An International, Interdisciplinary Journal*, *17(7),* 994 – 999.

Stewart, L., Usher, K., Nadakuitavuki, R., & Tollefson, J. (2006). Developing the future nurse leaders of Fiji. *Australian Journal of Advanced Nursing, 23*(4), 47 - 51.

Stordeur, S., D'hoore, W., & Vandenberghe, C. (2001). Leadership, organizational stress, and emotional exhaustion among hospital nursing staff. *Journal of Advanced Nursing, 35*(4), 533 - 542.

Street, A. F. (1992). *Inside Nursing: A Critical Ethnography of Clinical Nursing Practice*. Albany: State University of New York Press.

Swage, T. (2004). *Clinical Governance in Health Care Practice*. Edinburgh: Butterworth Heinemann.

Thomas, J. (1993). *Doing Critical Ethnography*. Newbury Park, California: Sage Publications Inc.

Thomas, P. (2006). The international migration of Indian nurses. *International Nursing Review, 53*, 277 - 283.

Thompson, P., Navarra, M. B., & Antonson, N. (2005). Patient safety: the four domains of nursing leadership. *Nursing Economics, 23*(6), 331-333.

Tuhiwai Smith, L. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. London and New York: Zed Books Ltd.

Tuivaga, J. (1998). Fiji. In T. Tongomoa (Ed.), *Pacific Women: Roles and Status of Women in Pacific Societies* (pp. 1-21). Suva: Institute of Pacific Studies of the University of the South Pacific.

Usher, K. (2003). *Fiji School of Nursing Scoping Mission*: Ministry of Health, Fiji.

Usher, K., & Lindsay, D. (2003/2004). The nurse practitioner role in Fiji: results of an impact study. *Contemporary Nurse, 16*(1-2), 83-91.

Usher, K., Rabuka, I., Nadakuitavuki, R., Tollefson, J., & Luck, L. (2004). Nursing and the development of nursing education in Fiji. *Australian Journal of Advanced Nursing, 21*(3), 28-31.

Vidich, A. J., & Lyman, S. M. (2003). Qualitative methods: their history in sociology and anthropology. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Landscape of Qualitative Research: Theories and Issues* (2nd ed., pp. 55 - 129). Thousand Oaks, California: Sage Publications, Inc.

Vincent, C. (2001). *Clinical Risk Management: Enhancing Patient Safety*. London: BMJ Books.

Vroom, V. H., & Yetton, P. W. (1973). *Leadership and Decision-Making*. Boulder, CO: Westview Press.

Wall, D., & Window, S. (2004). Clinical governance support team: patients as a virtue. *Clinical Governance: An International Journal, 9*(1), 67-72.

Westwood, R. (2006). International business and management studies as an orientalist discourse. A postcolonial critique. *Critical Perspectives on International Business*, 2(2), 91-113.

White, P., Pringle, D., Doran, D., & McGillis Hall, L. (2005). The nursing and health outcomes project. *Canadian Nurse, 101*(9), 15-18.

White, R. K., & Lippitt, R. (1960). *Autocracy and Democracy: An Experimental Inquiry*. New York: Harper & Row.

Wielkiewicz, R., & Stelzner, S. P. (2005). An ecological perspective on leadership theory, research, and practice. *Review of General Psychology, 9*(4), 326-341.

Wilkinson, J. E., Rushmer, R. K., & Davies, H. t. o. (2004). Clinical governance and the learning organization. *Journal of Nursing Management, 12*, 105-113.

Williams, J. (2005). Learning from mothers: how myths, policies and practices affect the early detection of subtle developmental problems in children. Unpublished PhD thesis: James Cook University, Townsville.

Williamson, T. (2005). Work-based learning: a leadership development example from an action research study of shared governance implementation. *Journal of Nursing Management, 13*, 490-499.

Willis, P. (1977). *Learning to Labour*. Hants. England: Saxon House.

Wilson, R., Runciman, W. B., Gibberd, W., Harrisons, B., Newby, L., & Hamilton, J. (1995). The quality in Australian health care study. *The Medical Journal of Australia, 163*(6), 458 - 471.

World Health Organization. (2005). *Guide to workforce development in post-conflict environments*. Geneva: World Health Organization.

World Health Organization. (2006a). *World Alliance for Patient Safety: Forward Programme 2006 - 2007*. Geneva: World Health Organization.

World Health Organization. (2006b). *Working together for health: The World Health Organization Report 2006*. Geneva: World Health Organization.

World Health Organization. (2006c). *The work of WHO in the Western Pacific Region: July 2005 - June 2006 Report of the Regional Director*. Manila: World Health Organization Western Pacific Region.

World Health Organization. (2006d). *Working together for health: The World Health Report 2006: Policy Briefs*. Geneva: World Health Organization.

World Health Organization. (2006e). *World Health Organization Knowledge Management Global Operational Plan 2006 - 2007*. Geneva: World Health Organization.

World Health Organization. (2006f). WHO Statistical Information Systems (WHOSIS). Retrieved from http://ww.int/countries/fji/en on 12 March 2007

World Health Organization Regional Office for the Western Pacific. (2005). *Integrating Poverty and Gender into Health Programmes: A report on surveys of health ministries and educational institutions*. Geneva: World Health Organization.

Yamanika, K., & Piper, N. (2005). *Feminized Migration in East and Southeast Asia: Policies Actions and Empowerment*. Geneva: United Nations Research Institute for Social Development.

Yoder-Wise, P. (2003). *Leading and Managing in Nursing*. St. Louis: Mosby.

Young, R.J.C. (2001). *Postcolonialism: An Historical Introduction*. Oxford: Blackwell.

Young, R. J. C. (2003). *Postcolonialism: A Very Short Introduction*. Oxford: Oxford University Press.

Appendices

Appendix A: Approval for Research (Fiji Ministry of Health)

DINEM HOUSE
88 AMY ST., TOORAK
BOX 2223, GOVT. BUILDING
SUVA, FIJI

MINISTRY OF Health
Shaping Fiji's Health

PHONE : (679) 3306177
FAX : (679) 3306163
EMAIL: info@health.gov.fj

Reference: MD 18/2/54 Date: 05.05.2005

Ms Lee Stewart
School of Nursing Sciences
James Cook University
Townsville
Queensland 4811
AUSTRALIA

Fax 07 – 478[6468] – 4026

Dear Ms Lee

RE: REQUEST FOR PhD PROJECT

I refer to your letter dated 7 March 2005 explaining your interest in pursuing your research towards your PhD focusing on Nursing Leadership in Fiji within the context of Clinical Governance.

The Chief Executive Officer, Health, Dr. Lepani Waqatakirewa has approved your request and the Ministry of Health through the Director of Nursing and Health System Standards will provide you with assistance as required.

We wish you well in this pursuit as we see the benefits that we may also reap at the completion of your project.

Best wishes.

Yours sincerely

.....
[R. V. Nadakuitavuki] Mrs
for **Chief Executive Officer, Health**

Appendix B: Letter of Introduction & Information Sheet

Letter of Introduction

Dear_____

As part of my higher degree studies at James Cook University, I am interested in interviewing nursing leaders in Fiji. If you are interested in participating in this study (being interviewed), please read the attached participant information sheet. If you have any questions in relation to this study, or the interview, please make contact according to the information provided on the participant information sheet.

Thank you for your time,
Yours sincerely,

Lee Stewart
Lecturer
School of Nursing Sciences
James Cook University.

Participant Information Sheet

Hello, my name is Lee Stewart and I am conducting a project as a Masters by Research student at the School of Nursing Sciences, James Cook University, Townsville, Queensland, Australia. The focus of my project is nursing leadership in Fiji. I am particularly interested in how the introduction of the clinical governance framework contributes to the changing role of nurse leaders in Fiji. With the agreement of the Ministry of Health, Fiji, I will be investigating the impact of introducing the clinical governance framework and the probable increased leadership accountability for effective nursing practice which will result from this.

In order to do this, one of my major strategies is to conduct individual interviews with senior nursing leaders/managers in Fiji. I would like to interview six (6) people in senior nursing leadership/management positions in Fiji.

If you agree to be interviewed for this project, this is the way that it will happen. We will meet at a time and place which is suitable for you, and will be in a private room alone together speaking for approximately one (1) hour. I will be tape-recording the

interview, and will also be making notes while we are speaking. Examples of the sort of questions I will be asking in the interview are:

- How does someone become a senior nursing leader in Fiji (in a position like yours?)
- What do you think about the strategies for improving health care that are being tried in Fiji?
- What is it like to be leading and managing so much change in nursing in Fiji?

If you agree to being interviewed, you are still able to change your mind and stop the interview at any time while we are speaking, or you can choose not to answer any of the questions that I ask you.

I will write the interview up later for analysis, and it will become part of the thesis for my Masters degree, and may also be part of journal articles that I write for publication, and conference presentations that I will be making. Your name will not be used at all; I will create pseudonyms for everyone that I speak with, and will do everything possible to ensure your anonymity. The audiotapes that I use for recording the interview, and all the notes that I make will be locked away where I am the only one who can access them. They will be destroyed by me five (5) years after publication of the findings from my study.

It is also important that I point out that being part of this interview is your personal decision, and is in no way is related to your conditions of employment with the Ministry of Health.

When you have read this information sheet, if you have any questions you can contact me by e-mailing me at Lee.Stewart@jcu.edu.au, or if that is not possible, you can contact Mrs.Rusieli Taukei at the Ministry of Health, and she will pass your questions on to me.

If you agree to be interviewed, as a requirement of James Cook University, you will be required to sign a consent form just before the beginning of the interview.

My Principal Supervisor for this project is Associate Professor Kim Usher. Her contact details are: School of Nursing Sciences, James Cook University, Townsville, Queensland, Australia. 4811. Telephone: +61 07 4781 4261. E-Mail: Kim.Usher@jcu.edu.au.

If you have any concerns that you would like to discuss after the interview, Mrs. Rusieli Taukei at the Ministry of Health has agreed to be available if required.

If you have any questions on ethical considerations regarding this project, please contact Ms. Tina Langford, Ethics Administrator, The Research Office, James Cook University, Townsville. Queensland. Australia. 4811. Telephone: +61 07 4781 4342. E-Mail: Tina.Langford@jcu.edu.au.

Thankyou for taking the time to read this information sheet and I look forward to the opportunity to discuss your involvement in the project.

Lee Stewart
Lecturer
School of Nursing Sciences
James Cook University
Townsville
Queensland
Australia. 4811.

Appendix C: Consent form

PLEASE NOTE: THE INFORMED CONSENT FORM MUST BE PRESENTED TO THE HUMAN ETHICS SUB-COMMITTEE ON JCU LETTERHEAD/OR STATED IN THE ETHICS APPLICATION THAT THE RESEARCHER WILL PRESENT THE INFORMED CONSENT FORM TO PARTICIPANTS ON JCU LETTERHEAD

INFORMED CONSENT FORM

PRINCIPAL INVESTIGATOR ***Lee Stewart***

SCHOOL ***School of Nursing Sciences***

CONTACT DETAILS ***Lee.Stewart@jcu.edu.au***

School of Nursing Sciences, James Cook University, Townsville. QLD, Australia, 4810

PROJECT TITLE: ***Explore the Introduction of a Clinical Governance Framework and its Contribution to the Changing Role of Nurse Leaders in Fiji***

DETAILS OF CONSENT:

I understand that this project aims to explore the introduction of a clinical governance framework in Fiji, with a particular focus on the contribution of this to the changing role of nurse leaders. I understand that the interview will last for about 1 hour and that the interview will be audio-taped (and will be transcribed at a later date) and that the researcher will also at times be taking hand-written notes during the interview. I understand that my privacy, confidentiality, anonymity and safety will be respected and maintained at all times, and that I have the right to withdraw from the interview at any stage, or to refuse to answer any question during the interview. I understand that the outcomes of this study will contribute to the fulfilment of the requirements of a Masters by Research degree at James Cook University and that the information gathered from this study is also intended to contribute to several publications and conference presentations.

Principal Supervisor: Dr. Kim Usher, School of Nursing Sciences, James Cook University, Townsville, QLD. Australia, 4810. Telephone +61 7 47814261. e-mail: Kim.Usher@jcu.edu.au

CONSENT

The aims of this study have been clearly explained to me and I understand what is wanted of me. I know that taking part in this study is voluntary and I am aware that I can stop taking part in it at any time and may refuse to answer any questions.

I understand that any information I give will be kept strictly confidential and that no names will be used to identify me with this study without my approval.

Name: *(printed)*	
Signature:	**Date:**

Appendix D: Outcomes from thesis

Journal Articles

Stewart, L., Usher, K., Nadakuitavuki, R., & Tollefson, J. (2006). Developing the future nurse leaders of Fiji. *Australian Journal of Advanced Nursing,* 23(4), pp.47-51.

Stewart, L. & Usher, K. (2007) Carspecken's critical approach as a way to explore nursing leadership issues. *Qualitative Health Research – An International, Interdisciplinary Journal, 17(7), pp.994 – 999.*

Stewart, L. & Usher, K. submitted. Powerful beyond expectations: A critical ethnographic study of nursing leadership and clinical governance. *Journal of Transcultural Nursing.*

Conference Presentations

2006	Clinical Governance in Fiji, *Leadership in Health Care Conference,* Brisbane, November, 2006
2007	Clinical Governance in Fiji, *ICN Conference*, Yokohama, May 2007