A true story of rise and fall of good leadership

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Abstract

The purpose of this study is to gain more understanding about leadership as a socially constructed phenomenon at an organisational level. This paper specifically examines the factors that develop or destroy leadership that has been praised as good. The longitudinal qualitative data was gathered in a hospital in Finland. The data consisted of 52 narrations produced by head nurses. It was analysed using a content analysis method. Based on data from the first time point, the leadership there was humane: based on cooperation, confidential, ready to listen, equitable, encouraging, and supportive. Ten years later the leadership was described as bad, non-uniform, “lost” and “in transition”. Leaders felt that they were lonely and without support. The dramatic changes are related to turnover of managers, big structural changes, an unclear future and a strong emphasis on cost reduction and efficiency. The data revealed that head nurses expect and appreciate clear, caring, communicative and participative leadership from their own supervisors. The research story in the hospital indicates, that leadership demands intensive and conscious leadership in order to develop and remain as good. The main contribution of this research is the longitudinal qualitative research design which is based on narrations produced by head nurses. Additionally the study views leadership on organisational level, which is still relatively rare in the field of leadership research.

Key words: leadership, head nurses, change, organisation level

Introduction

The quality of leadership is a target of great interest for many reasons. It has been addressed as an important factor for positive feelings (Rowold and Rohmann, 2009), organizational climate (Koene et al., 2002), optimism at work place (McColl-Kennedy and Anderson, 2002), innovativeness (Charbonnier et al., 2010), job satisfaction (Bartram and Casimir, 2007; Raja and Palanichamy, 2011), engagement to organization (Chi et al., 2008; Limsila and Ogunlana, 2008), organizational and individual learning (Campos and Rodriguez, 2011), performance on individual (Limsila and Ogunlana, 2008; Huang et al., 2010; Wang et al., 2011) and organisational level (Alimo-Metcalfe, et al., 2006; Vigoda-Gadot, 2007; Kathuria et al., 2010), and subordinate’s notion of his/her self-efficacy (Walumbwa and Hartnell, 2011), just to name a few.
In the light of the above, the burden on leaders’ shoulders seems substantial. Individual leaders are quick to be condemned “guilty” if things are in a bad state in organisations. Leadership is widely still seen as a phenomenon mastered by individual leaders in their units. Also, the focus in research fields is still often on individual leaders: their traits, characteristics, behaviours, roles, styles, and abilities. Within this research paradigm there is a variety of definitions which see leadership as an individual –centred phenomenon, often with a heroic nuance (Barker, 1997, 2001). Typically, the concept of leadership is defined as follows: ”Leadership is the process in which an individual influences other group members towards the attainment of group or organizational goals” (Stogdill, 1974: 9–10; Northouse, 1997:3). Despite of the growing discussion on alternative views to leadership like post-heroic (Fletcher, 2004) and shared leadership (Pearce and Conger, 2003), the main stream in leadership discussions still strongly relies on “great man” theory of leadership and emphasizes individual leaders as creators, actors and masters of quality of leadership in organizations. We tend to have a strong desire for superior human beings as our leaders and thus problem solvers in organisations.

Broader definitions of leadership have conceptualized leadership as a process in a social system. For example, Gemmil and Oakley (1992) defined leadership as “a process of dynamic collaboration, where individuals and organization members authorize themselves and others to interact in ways that experiment with new forms of intellectual and emotional meaning”. Thus, the core of it is a process of communication, influence and interaction between leaders and followers (Dachler & Hosking, 1995; Northouse, 1997). Barker (2001) has even stated that 1) leadership is not a function of the person in charge, but a result of collective will organized to meet individual needs, 2) leadership is a process of adaptation and of evolution, and 3) it is a process of energy, not structure.

A leadership process is highly context bound. It is not just the social context, but also the local and historical contexts, which define leadership (Dachler & Hosking, 1995; Ladkin 2010: 27-28). In this process the actors have differing roles and responsibilities that may change from situation to situation. For example a contingency theory of leadership incorporates different forms of leadership across environmental and task design contingencies (Gibbons 1992). The organisational environment gives both restrictions and demands for leadership activities. For example, the content and nature of leadership position (Vroom and Jago, 1979), as well as the level of organization (Hunt, 1991), affect the way a leader can carry out her/his leadership. Additionally, research has shown that leadership varies both across organizational (Brooks, 1996; Hennessey, 1998; Lok and Crawford, 1999; Pillai and Meindl, 1998; Ogbonna and Harris, 2000; Block, 2003) and national cultures (e.g. Reber et al., 2004; Collard, 2007; Holt et al., 2009). Leaders on all levels of an organization have been found to lay stress on those things which the organization seems to value and emphasize (Schein and Lippit, 1979; Berlew and Hall, 1979). The influence of subordinates’, peers’ and upper level leaders’ is also important (Tsui, 1984).

A leadership exists in relation to purpose and goals of activity (e.g. Northhouse, 1997: 3). The content and nature of goals influence the nature, strength and direction of leadership needed. Leadership is different in context where the purpose is nurturing patients compared a context where the goal is to build a new building for a hospital.
Ladkin (2010) conceptualized the interactive and context-dependent nature of leadership in her model of ‘leadership moment’ (figure 1.). It identifies the “pieces” of leadership which interact in order to for leadership to be experienced. Leaders relate to followers and together they interact within a particular context, and work towards a purpose. All these “pieces” also interact dynamically. (Ladkin 2010: 25-30.)

Figure 1. Leadership “moment” (Ladkin 2010: 28).

The interesting question is how the organization as the sphere of activities and a social community formed by the leaders determines the collective and individual leader’s leadership and the mental models that form its background. The theory of socio-constructionism (or social constructionism) aims to explain the process of individual level meaning making in continual dialogue with the social environment. According to it the ideas, thoughts and actions are the result of ongoing processes of interactions and interpretations between human beings (Berger and Luckmann, 1967). Thus, a nature and constructions of phenomena such as “leadership in an organisation” are continually changing, complex and within rich local discourses (Cunliffe, 2008). In this process power plays an important role in organisations.

Nevertheless, in organizations leadership seems to develop and maintain some typical and relatively long-lasting patterns and routines despite of the continual changes in organisational environments. Gemmil and Oakley (1992: 114) have even stated that leadership can also be seen as an ideology which supports the existing social order. In fact, the routines of leadership may be important in this more and more chaotic world where sudden changes demand a lot of energy from the people to persevere through. The theory of structuration (Giddens, 1984) explains the important routine nature of practices: 1) practices are institutionalized in social structures that remain unchanged across time and space, 2) institutional social structures are embedded in the daily practices, and 3) structures endure the tacit knowledge and practical consciousness of actors seeking “ontological security”. The social structures both stem from, and also create, collective managerial thinking  (see eg. Kunda 1990; Hodginson, 1997; Jarzabkowski, 2009).
The interesting question is why and how leaders in an organization tend to seek and adapt in common routines and activities. A literature of organizational culture, which to a great degree is based on the idea of social constructionism, offers some insights to the question. Organizational culture generally refers to an established way of behaving in an organization and to the values and convictions that determine it (Pettigrew, 1979; Schein, 1996: 236). It has a harmonizing effect on the activities of a group. It creates a common organizational identity, promotes commitment, brings stability to the social system, and helps the members to interpret the organization and its environment as well as the relation between them (Smircich, 1983; Strauss and Quinn, 1997: 7). Adaptation to the organizational culture confers an accepted position on the members of the organization and, simultaneously, provides social security (Van Maanen, 1977). One dimension of organisational culture is the density of it, i.e. its coherence, strength and intensity. Within the broader frame of organizational culture, we can think about leadership culture as one subculture. Thus, the stronger the leadership culture is, the more strongly it imposes on the leaders’ commitment to shared aims, motivation for attaining them, and common models of operation and structures which support the function and success of the organization (Deal and Kennedy, 1982). A significant change of organizational culture has been asserted to take from six to fifteen years (Uttal, 1993), but can speed up on the impulse of some crisis or the threat of one (Brooks, 1996).

There is still need for widening leadership research in a socio-constructionist direction in academic literature. We still don’t know very much about the dynamics how leadership may develop and change on collective level in an organization. Moreover, we do not know what causes the positive or negative developments in collective level leadership. “Collective level leadership” refers to common similarities in carrying leadership in a group of leaders in an organization.

The aim of this paper is to gain more understanding about the phenomenon of leadership at the organizational level and the dynamics it is developed or destroyed. The answers for these questions have been sought through two sets qualitative data gathered in a hospital within 9 year’s period. The questions for the data is: What is the leadership like in the hospital in the former situation (evaluated as “good”) and in the present situation (evaluated as “bad”) and how the nurse leaders interpret the main changes and the factors behind the changes. The “good or bad leadership” in this paper refer to interpretations made by leaders themselves involved in leadership process in two historical, local and social contexts in the hospital.

In the next sections I present the design of the research and the main findings concerning the state of organisational level leadership in The Hospital in two different points. Additionally I make some interpretations about what changed and why in the leadership of the hospital. Finally, I make some interpretations concerning the process by which good leadership was ruined at the organizational level in The Hospital.

**Research design**
This research story begins in 2001 in a hospital, which offers the majority of psychiatric services provided by a big University Central Hospital in Finland. It is located apart from other departments of the hospital. It provides treatment for both adults and adolescents. The services include inpatient care in psychiatry, psychiatry outpatient clinic and therapy services (called “The Hospital” in this paper). The management of The Hospital comprises both the doctors’ organization and the nurses’ organization. The head of the hospital is a psychiatrist and the deputy director is a nursing director. This study focuses on nursing organization. The informants in this research comprise mainly head nurses, but also nursing directors and assistant head nurses. In this paper I call them all simply as “leaders”.

In 2001 The Hospital participated in a quantitative study describing the manifestation of coaching leadership skills among leaders (Viitala, 2002). The group of 30 supervisors (5 nursing directors, 14 head nurses and 11 assistant head nurses) were assessed by all of their subordinates in 32 items describing leadership that facilitates good performance, learning, and wellbeing at work. It turned out, that the nursing leaders in The Hospital got exceptionally high estimates compared with any other leader groups among the 36 organizations that participated in the study. According to the results, the quality of leadership was extremely high. Their leadership excellence was then investigated in more depth in 2002. About ten years later the praised leadership culture in The Hospital had been ruined. In 2011 the follow-up research revealed that the leadership culture had indeed changed significantly. Both data consist of written texts produced by the nurse leaders. In them the leaders expressed their own conceptions, in an informal manner, of what the leadership in The Hospital is like and why it is as it is. In both data gathering processes also field notes were made: about the atmosphere, body language, discussions and environment.

I chose to ask the informants to write narrations instead of being interviewed for several reasons. Firstly, all of the informants were used to writing in their job and thus writing is natural to them. Secondly, writing sessions were possible to organize as part of their training compared to time-consuming face-to-face interviews. Thirdly, in this way the data could be gathered totally anonymously because not even the researcher could identify the person. In this way the possible influence of the researcher could be avoided to some degree.

I participated in the sessions and thus presented each research question and its background personally to participants, answered questions related to the matter concerned, offered enough time for writing, and collected the data personally. All the leaders were also been given an opportunity to be interviewed instead of writing but all of them preferred to write. The narrations they produced varied from one to three pages.

The aim here was for the data to drive the analysis. A nature of content analysis used here was merely so called open analysis (Mc Kenoe, 1995) where analysis identifies the dominant messages and subject matter within the text. Both the first and the second data were analysed in the same way. In the first phase of the analysis several through readings were done and Mind Maps were produced about the topics. In the second phase the writings were read very detailed and the Excel-program was used as the technical aid in categorizing the themes. Each participant’s views were compressed into one line in such a way that each individual theme was placed in its own cell. As the analysis progressed, these cells could be arranged in
theme-based columns without a single writer’s account being broken. Each of the narrations was written in the table word for word. Finally, the Mind Maps and categorizations made in Excel were compared. After that the final interpretation was written out.

Leadership in The Hospital ten years earlier

The first qualitative research was carried on in 2002 in order to understand why the leaders in that particular organization got so high estimates of their leadership from the subordinates. Five nursing directors, 14 head nurses and 11 assistant head nurses were asked to describe the leadership in The Hospital among the nurse organization. There were both men and women in the group, women representing majority. Their age varied from 34 to 62. Some of the leaders had already several years of experience, but others were just developing their professional skill as leaders.

My question to the leaders was: “What is leadership like in The Hospital and what are the factors that have made leadership such as it is there?” The empirical data was gathered in three meetings within six months and it comprised 30 narrations.

According to the narrations, a “we-spirit” prevails in the organization along with a tradition of working together, and leadership is above all cooperation between leaders and subordinates. Leadership was described with terms of human, encouraging, supportive, ready to listen, based on cooperation, confidential, and equitable. Decision-making is participative. Leaders trust their subordinates and give them power, responsibility, and freedom of action. Appreciation between leaders and subordinates is mentioned in several times. Several respondents said explicitly that they receive support and care in the organization from their own superior.

In several narrations it was noticed that in leadership one can see the same principles as in the patient–nurse relationship. These have been described by three words: warmth, nearness, and trust. The clear meaning of the basic task is, according to three respondents, also a strength, which supports leadership.

A sense of community in The Hospital was mentioned as one reason for the good leadership in 12 narrations. Several respondents have said that people really are seen as important in the organization. In describing leadership culture of The Hospital following expressions were used repeatedly: discussion, familiarity, commitment, openness, authenticity, sincerity, dealing with problems together, warmth, community spirit, communal working practice, and high ethical standards. The atmosphere of The Hospital is described for example as safe, free and easy, and supportive.

"Long traditions: work is doing things together. The psychiatry clinic seems to be filled with a sense of community. Everyone has responsibility, but managers ultimately answer for things.” (Leader 22/1)

"The atmosphere is respectful of each other, encouraging and based largely on positive feedback. The leadership atmosphere, which I have experienced personally, is warm, clearly structured and demanding in its own way." (Leader 26/1)
"Notification is done well. In terms of questions of issues, the aim is for many-sided handling of the issues and brainstorming. Leadership is trusting and distributes responsibility to each level. Human resources are highly valued and cooperation focused" (Leader 21/1)

"Based on my experiences, our area has a humane leadership culture. I feel that it's on healthy, professional and humane cornerstones." (Leader 27/1)

The systems, structures, and action models that have shaped and directed leadership are dealt with a lot in the narrations. The leaders expressed in their narrations that they have common sense about their important leadership activities. In fact, of the respondents 13 mentioned as explanations of good leadership the way in which leadership activities in the organization are organized referring to structures, processes, and models of action. They mentioned as examples of them bilateral developmental discussions between supervisors and subordinates, regular work–unit meetings at different levels of the organization, assessment and planning days arranged twice a year, annual quality days, development projects, development planning practice, result state measures, the communal training plans, and the discussion meetings of the departments. Also the information channels are described as clear. In general, information is described as good, open, and proactive in the organisation.

"Briefing is open and consistent. Common rules are agreed upon together and they are adhered to. The common thread to leadership is that leadership needs to always support doing the basic work, and that the patients are being cared for and that the personnel are well. (Leader 12/1)

"Leadership culture and managerial work are not bureaucratic and top down directed. This enables a flexible and purposeful utilisation of know-how and expertise. Keeping in contact with managers and vice versa is easy. When the members of the work community need help and for instance information, they can get it from each other and their superiors." (Leader 5/1)

"A negotiating attitude, incorporating the employees into decision making, open discussion and briefing have carried over years and numerous units being closed down. It has made it possible to guarantee employees have a reasonably safe mind-set about the continuation of things." (Leader 4/1)

"Leadership is getting a lot of attention: training, supervision of work, cooperative thinking, development discussions, leisure time activities together etc." (Leader 17/1)

In the narrations both the own supervisors and subordinates were appreciated by the leaders. Caring and concentrating of own superior was praised by several leaders. In fact, many had mentioned his/her own supervisor as a good example as a leader. The relation to own superiors was characterized by the following expressions: good example, trust, support, freedom, straightforwardness, resoluteness, involvement and participation. The subordinates got only positive mentions such as motivated, enthusiastic and skilled.

"My manager has always been able to see a little further than others, and has pushed us to even those areas we may not have known to direct ourselves to. Cooperation with the manager has been of utmost importance" (Leader 14/1)
"My area, at least, has a highly motivated personnel who develop their work through various projects and they have good, motivated department managers. Basic duties are delivered even in difficult times." (Leader 7/1)

"Your own strength and ability is supported by a great work community, your own substitute and employees who are enthusiastic about their work and developing it. And the colleague affinity that I've encountered at work!" (Leader 11/1)

Overall, the writings on leadership in The Hospital were like-minded and very positive. Among the accounts were only a couple of more critical views. Negative narrations were rare exceptions.

Among those few exceptions some concerns raised up. The change of one nursing director had to some extent brought confusion. She had somewhat deviated from the customary leadership and caused confusion and anxiety. Some head nurses experienced a strengthening of management at the expense of humane leadership. Also some nightmare scenarios were given in the narrations. The raising speed of changes was considered a problem bringing uncertainty, crises, bureaucracy, and frustration. Although many advantages were seen in the increase of development activities, this was also seen as a sign of constantly intensifying demands. Changes of the organization were mentioned several times as a potential threat for the good leadership.

"There's starting to be not enough time for instance for being together with subordinates, and listening to them. The clearer your own vision is about leadership, the easier it is to work." (Leader 24/1)

"There are more and more new things. The work becomes more demanding. In the long run, it's difficult to make plans, because changes in the [area] are so so fast." (Leader 28/1)

"My own head nurse has changed. In my personal opinion, my current superior is bossy. I’ve now had to learn an entirely new culture. We now have better cooperation, as I’ve learned to adopt a different attitude. My mental resources are supported by good relationships with colleagues. I can share my feelings about the current situation with them." Leader 3/1

“Right now I feel that leadership here is in some sort of state of change. A manager who has been here for a long time is retiring and we're looking at an organisational restructure.” (Leader 13/1)

**The follow-up study nine years later**

About nine years later I met one of the head nurses by accident in a seminar in the city where The Hospital is located. In that brief meeting she expressed that the previously praised leadership in The Hospital is ruined. That unexpected encounter became a trigger to continue with a follow-up study in The Hospital. This time the aim was to understand, what might be the changes and their causes in the light of nurse leaders’ own interpretations.

The data gathering was organized basically in the same manner as ten years ago. This time 21 head nurses and assistant head nurses participated in one writing session. They were men and women, representing different ages between 30 and 60. Some of them were experienced as nurse leaders, but this time even more of them were just learning. Couple of the
experienced leaders were new in The Hospital, and more of them had changed the ward or were new in leadership position.

The matter that had changed crucially compared the previous data gathering situation was the atmosphere. Last time the writing sessions in 2002 took place in the beautiful mansion which is located in the big garden of the hospital, but this time now we met in a blunt classroom in the hospital building. When the leaders were lively, chatty and laughing ten years earlier in the same situation, this time the leaders were silent and seemed tired, pensive and reserved.

I asked the leaders to write freely about their own thoughts of leadership in the ward and the factors behind the state of the leadership. I also asked those who had worked several years in The Hospital to write about possible changes in its leadership, and if something has changed, what might be the factors that have caused the changes.”

The data consisted of 21 narrations. The content of them was this time very different compared to previous time. In these narration leaders did not talk about leadership as a positive, collective resource. The writings were now primarily negative and critical. In general, leadership was described as bad, non-uniform and even non-existent. According to some narrations, leadership in The Hospital is “lost” and “in transition”. Some felt, that it is conservative, and some just saw it as locked in place. Leaders feel that no one bears the overall responsibility of leadership in The Hospital.

According to respondents nursing directors are distant, overloaded and lost contact with the practical level work. In overall, the gap between leaders and subordinates, as well as developing and implementing exists at all levels in The Hospital. The leaders feel that they do not get information of changes, they cannot participate in developing and decision making, and they feel themselves just as administrative implementers of decisions made at upper levels. In that implementing task, according to them, they do not get decent support.

"Leadership has become distant from the employees. You get this feeling, that you can’t influence your own tasks in the same way as before.” (Leader 23/2)

"There’s a feeling, that the top level just notifies us of change and the need for it. They don’t justify the change or they give you some weak explanation.” (Leader 8/2)

“Leadership at our unit is in a rather severe state of change. Subordinates are easily left outside in these developments. I feel that leadership is lost. Head nurses are doing their work very distantly from everyday work and common practice.” (Leader 5/2)

"Leadership in our unit is also very short cited right now. Plans are made, some things are focused on, but then suddenly it’s all dropped.” (Leader 5/2)

Most of the leaders felt that their work as leaders has become more demanding and onerous. According to the narrations head nurses are more and more busy, overwhelmed by administrative work and thus drifted apart from their subordinates and practical work. Also assistant head nurses feel haste, diffidence in their leader positions and strong inadequacy in balancing between the leadership task and work with patients. The amount of work overall, and especially administrative work, have noted in several narrations.
Also the subordinates are seen more demanding than before, as well as the patients. Nurses are – according to the narrations – negative and overloaded with work, which causes a lot of sick-leaves. A lack of substitutes and recruitment problems make leading even more difficult. Some of the leaders mention also the attitude problems among the nurses, referring to the bad commitment to work and organisation. The patients are more unsatisfied than before which manifest itself for example the increasing amount of complaints.

"Are the managers of care professions in fact office secretaries? The ward level receives a constant stream of tasks that could probably be done by someone other than the head nurse. Then there would be more time for interpersonal interplay and cooperation, and the development of care work.” (Leader 16/2)

"Basic patient work has become more tightly scheduled, efficiency is increasingly evaluated with various measures. Temp shortages are always a problem. Work is constantly being done with a shortage of manpower. ” (Leader 15/2)

"The constant rush also wears on the managers. You should keep on top of so many things. Everything is counted calmly and the patients forgotten, which in turn reflects on the staff and ipso facto the managers.” (Leader 17/2)

Overall, leaders at all levels describe their work as well as their subordinates’ work as busy, lonely and more and more demanding. It seems, that at all the levels people feel that they do not get support. Leaders’ explanations for this state of leadership contained four main topics: obscure future of The Hospital, constant changes, the stress on efficiency and cost control and some changes in top management team. The main dark cloud in the sky in The Hospital was the prolonged hanging decision about the possible fusion of two psychiatric units of the university hospital. The political decision process had caused speculations and rumours among the personnel for years. The leaders felt that all the development is stuck because of the situation, or it is short-term and inconsistent. At the same time leaders experienced an overwhelming wave of changes coming from upper levels of the organization. The changes were for example structural changes, changes in IT-systems and in reporting. A lot of tasks had transferred from upper levels of the organization to lower levels. The information and participating concerning those changes were blamed as bad. In addition, the increasing amount of administrative work like reporting had – according to leaders – distanced them from subordinates and core of the work. Many of the leaders noted that the main guiding star in leadership is cost efficiency. Because of that many felt that the real leaders are now money and statistics and they are just stooges.

"Constant changes and financial pressure have increased steadily and make managing people ever more challenging.” (Leader 21/2)

"As a result of cuts the entire organisation is treading water. All kind of development has halted to a standstill. Managers are obviously at the receiving end of all the anger of disappointments” (Leader 5/2)

“At the moment, our biggest concern is the fate of the hospital in the future. I sincerely hope that the decision makers can come to some conclusion – whatever that may be. Development work has been stuck at a standstill for coming up to two years now as we wait for decisions.” (Leader 3/2)
“My superior, the nursing director, has been on leave of absence for years and my superior in that position has changed several times (4-5 different persons) with different kind of backgrounds. This variation is shown on lack of support.” (Leader 20/2)

One of the biggest differences in this data compared the previous one is the placement of the patient in the texts. The patient is almost totally missing. In couple of accounts patients were noted as demanding than before and thus a reason for growing burden at work. Some felt, that if some development activities exist, they are not related to the patient work. Some of the leaders wrote explicitly that patients have been forgotten in leadership at the moment.

“The purpose of our work disappears totally when a big group of people start to wallow in some issues which do not at all relate to care of our patients.” (Leader 7/2)

Overall, the main stream in the writings on leadership in The Hospital was also this time like-minded. Contrary to the views nine years ago, this time the common view concerning leadership in The Hospital was surprisingly negative. The general feeling in the texts was unhappiness. Positive narrations were a few exceptions and they were related to good relationship with the leader’s own superior, possibilities to training and possibilities to develop something inside one’s own ward.

Discussion

The purpose of this paper was to gain understanding about the state of leadership at the collective level, as well as the factors behind the states and the causes for the changes in the state. The main finding is that the leadership in The Hospital seem to be based heavily on group-thinking. Leadership in The Hospital was interpreted and described in a very uniform way as very good in 2002 among nurse leaders, as well as nine years later when it was described as bad in a very uniform way. In the first data the negative accounts were rare exceptions and in the latter data the positive comments were rare exceptions. Leadership was definitely something beyond behaviour and interpretations of single individuals. Thus, this finding lends support to the idea of leadership culture and a dynamics explained in the approach of social constructionism.

Additionally it lends support to the idea that leadership is strongly context bound. The significant changes in the whole university hospital level reflected to leadership in The Hospital. In fact, the leadership has changed dramatically about in ten years. One of the main differences was the way leaders positioned themselves in the two sets of narrations. In the first study the leaders spoke themselves as owners, actors and developers of good leadership in The Hospital. In the last study they spoke about themselves like victims, objects or witnesses of bad leadership. The major differences in the two data are analysed through Ladkin’s (2010) model of “leadership moment” in the table 1.

Table 1. Major chances in “leadership moment” in The Hospital

<table>
<thead>
<tr>
<th></th>
<th>Situation 2002</th>
<th>Situation 2011</th>
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<tbody>
<tr>
<td>Leaders</td>
<td>A strong team of leaders.</td>
<td>Dispersed group of lonely</td>
</tr>
</tbody>
</table>
Happy, satisfied, supported and proud of themselves as leaders. Owners of the leadership process.  

Distressed, unsatisfied and feeling inadequacy as a leader. Objects in the leadership process.

<table>
<thead>
<tr>
<th>Followers</th>
<th>A reliable group of high quality professionals who are committed to both the basic duties as well as the organisation.</th>
<th>An unsatisfied and tired personnel. Resistance to change amongst the old employees and commitment issues amongst the young employees; sick leaves, people coming and going and problems with recruitments.</th>
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<tr>
<td>Context</td>
<td>Changes were based on consistent developments decided upon by the organisation. Development work is intrinsic and involving. The hospitals situation is stable and internal changes minor. Resource problems have not manifested.</td>
<td>Changes are short sighted and cost-related. They come from high up. Resources have diminished. Tasks are moved downward in the organisational hierarchy. Internal structures and ways of working in the organisation have been changed. Changes arrive as tasks. The future of the hospital is uncertain.</td>
</tr>
<tr>
<td>Purpose</td>
<td>The basic purpose of work is crystal clear and directs all operations. Success of operations is evaluated mainly based on quality.</td>
<td>The basic task has been lost under managerial tasks and productivity aims. The success of operations is evaluated mainly based on figures.</td>
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In the next section I mirror the main findings to some of the views presented in the beginning of this paper.

A several author the core of the leadership process is the process of communication, influence and interaction between leaders and followers (eg. Gemmil and Oakley 1992; Dachler & Hosking, 1995; Northouse, 1997). In the story of The Hospital the most distinctive change in ten years’ period has occurred in that area. In the first data the common praised view was that there is a lot interaction between leaders and members, and in the latter data the most common blaming concerned the lack of it. To the interaction and communication entangled more or less all the other problems like lack of information of changes, insufficient possibilities to participate in development and decision making, feeling of being without support and missing the main purpose of work in the middle of haste. This
study supports the idea that core of the quality of leadership lays basically in communication.

In the narrations of leaders, there are many factors mentioned as causes for the change in leadership, but one of the most evident was changes in top management. In line with findings of Tsui (1984) tens of the leaders mentioned the previous top managers both as the important factor for the good state of leadership and as one of the main causes for the bad state in it. Top managers give both restrictions and demands for certain kind of leadership activities. I agree with Barker (2001), that leadership is not just a function of the person in charge, but I suggest, that is may be a result of that person leading the meaning making process among leaders in an organization. Somebody should take responsibility and care of leadership in an organisation. It should be like a garden, and not just a natural meadow.

Barker (2001) also claimed that leadership is a process of adaptation and of evolution. The data from The Hospital proves that in addition to that, the nature of leadership itself is in a process of adaptation and evolution in relation to changes in its environment. The Hospital is going through big structural changes alongside with growing demands for cost control. These developments are part of broader societal changes where the whole health-care – system is under restructuring. When nurses and head nurses are doing more of tasks in narrowing timeframes and with diminishing resources, there is definitely less space for developing leadership and leading people in a communicative and participative way. The most often mentioned reasons for separation between leaders and followers were namely haste and administrative work. One can ask, are these changes something that truly weak the leadership in organizations. If so, we should be prepared to say goodbye more and more often to good leadership. In the light of the data one area that suffers in restructuration is easily leadership work.

Additionally Barker (2001) suggests that leadership is a process of energy and not structure. I agree with him that it is a process of energy. In the first study the strong and positive energy could not be just read in the texts but also felt in atmosphere in writing sessions. In the latter situation, the feeling was very different. The group of leaders were lost their energy. If that appearance is true also in The Hospitals every-day life, it must effect radically on nurses and patients. Barker has said that leadership is not structure, but I found the structural issues very important factors for the good leadership that took place in The Hospital ten years ago. Now the structures were in transformation and unclear and because of that the leaders felt that everything was fuzzy. Thus I suggest that in the more and more complex and fuzzy world some clear structures are even more important in leadership just to bring some clarity to leaders’ work.

Leadership exists in relation to purpose and goals of activity (e.g. Northouse, 1997: 3). Probably the saddest change happened in leadership work in relation to the purpose of the organisation. Several leaders wrote about the missing patient from the focus of development and management activities. In the first data the strong and shared sense of ultimate purpose of work was the main anchor for leaders’ deep feeling of doing important work. In the recent data they wrote with ashamed because of losing the thread at work.
According to Uttal (1993) a significant change of organizational culture takes from six to fifteen years. In the case of The Hospital the change in leadership culture as a subculture took place about nine years. This research gives strong evidence that leadership can be intentionally changed and it can be unintentionally destroyed.

To conclude, the aim of this paper was to gain more understanding of the phenomenon of leadership at the organizational level and the dynamics it is developed or destroyed. The main question for the data was: How do the head nurses interpret the contents, causes and effects of “spoiled” leadership compared to the previous “good” level? The answer could be: “Good leadership do not live without conscious nurturing. If you forget it, you loose it.”

This study is a story of one hospital and thus it is important to consider that it does not try to make any generalizations. What happened in this case was that leadership was socially constructed among this specific group of people and in this specific environment of The Hospital and the country. Nevertheless, as Eisenhard (1989) has said, if something is possible in one case, it is also possible in some other cases. In general, a case study (see ; Eisenhardt, 1989, Yin, 1984), especially in long-term setting, proved to be very suitable for investigating leadership more in-depth in real world setting. Long-term research contact to the unit made it possible to learn to know and understand the research context thoroughly, build trust with people in a unit and therefore get honest data, observe the changes in range of time and collect not only primary data but also different kind of secondary data without straining the people too much at one time. This study challenges researchers to further investigate the leadership on collective level, especially the development of it, in different kind of contexts and situations.

References


Barker, R.A. (1997), “How can we train leaders if we do not know what leadership is?”, Human Relations, Vol. 50 No.4, pp. 343-363.


