2019-09-10

# Understanding Role Transitions: Bedside to Boardroom

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# Understanding Role Transitions: Bedside to Boardroom

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

GRADUATE PROGRAM IN NURSING

CALGARY, ALBERTA

SEPTEMBER, 2019

## Abstract

The nurse manager (NM) role is an increasingly complex and vital role, providing a link between patients, staff, and the larger health system. Experienced nurses who demonstrate clinical expertise are often promoted to the NM role without prior leadership experience or training. As such, the transition from frontline nursing into this role can present significant challenges, leading to decreased job satisfaction, attrition, and poor staff and patient outcomes. Five new NMs were interviewed to gain an understanding of their experience with role transition. Based upon these conversations, this study found that moving from a frontline nursing role to that of an NM presented unique challenges in terms of negotiating a new professional identity, shifting personal and professional relationships, and setting reasonable expectations and boundaries within a new and unfamiliar context.



*Keywords:* nurse manager, leadership, role, transition, professional identity

## Preface

This thesis is original, unpublished, independent work by the author, W. Gauthier. The descriptive findings reported in Chapters 4-6 were covered by REB18-0646, issued by the University of Calgary Conjoint Health Ethics Board for the project "Understanding Role Transitions: Bedside to Boardroom."

**Acknowledgements**

I would like to acknowledge and thank my supervisor, Dr. Lorraine Venturato; I am very appreciative of your ability to gently persuade me to write a thesis – your support and guidance made this undertaking attainable and enjoyable for me. Thank you for helping me to formulate my ideas in a way that was cohesive, meaningful, and helped me to hear what my topic was saying to me. You helped me to complete this work in a way that felt very authentic to my experience, which was invaluable.

To my supervisory committee, Dr. Graham McAffrey and Dr. Catherine Laing, thank you for the time that you were willing to invest in my thesis, and for the countless suggestions and improvements that you helped me to make it my writing. Your input and expertise made a significant difference in my work, and I am grateful for having had the opportunity to work with you.

To my NM colleagues that were willing to share their experiences in role transition with me, and who were able to be vulnerable in a role that does not encourage this quality, thank you. Your enthusiasm and engagement in my work brought this topic to life for me. Your openness made this feel more like conversations with friends than research.

To my family and friends, thank you for your constant support and encouragement as I worked towards this goal, and for always letting me know that you were proud of me for the work that I was doing. To Gerrad and Maggie, thank you for your constant patience, reassurance, and always reminding me of the reasons that I chose to do this. I love you.

To my colleagues and leaders that supported me along this journey and made it possible to write a thesis while working full-time, thank you for the inspiration you provided me, and for giving me a reason to not let you down.

## Dedication

This thesis is dedicated to the NMs that pushed me towards my own leadership journey, that have supported and inspired me along the way, and have helped me to understand role both their role transitions and my own.

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# Chapter 1: Introduction

The increasing complexity of the health care system, as well as the difficulty associated with the task of leading in such an organization, dictates the need for skilled managers. DeCampli, Kirby, and Baldwin (2010) described the nurse manager (NM) role as being a linkage between patients, the multi-disciplinary healthcare team, and administration. NMs must balance competing priorities, representing the interests of patients, staff members, and quality care, while at the same time considering the operational needs of the larger organization. The Canadian Nurses Association (2009) described the nurse manager as a multi-faceted position that encompasses diverse roles, including clinician, patient advocate, educator, information manager, and systems analyst. Despite the importance of this role, it is challenging to prepare new NMs for their transition from bedside nursing to formal leadership (DeCampli et al., 2010). Nurses who possess strong clinical skills are frequently promoted into management roles, despite having no formal training or qualifications in management (Titzer, Phillips, Tooley, Hall, & Shirey, 2013). According to Titzer, Phillips, et al. (2013), the actions of NMs have the potential to directly impact patient outcomes, quality of care, and the provision of healthy and thriving work environments. The success of the NM at leading their team tends to correlate with higher levels of employee retention and engagement (Canadian Nurses Association, 2009). Decreasing turnover in frontline nursing staff is important not only for the provision of a skilled workforce and decreasing money spent on training new staff, but also to maintain a supply of potential future leaders (Mackoff & Triolo, 2008).

According to the Canadian Nurses Association (2009), the average age of current nursing leaders ranges from 47 to 51 years old. While this includes those in entry level roles all the way to those working in an executive capacity, it demonstrates the importance of preparing a future

generation of leaders. Most of the aforementioned nursing leaders are within 10 to 15 years of retirement, meaning that at that point, the nursing profession could face a significant shortage of experienced and qualified leaders. With this being the case, it is increasingly important that the younger generation of nurses be willing to step into leadership and management roles, and that new leaders are supported to make that transition successfully. Titzer, Phillips, et al. (2013) found that a lack of preparation and support for NMs could result in decreased stability within an organization's leadership team and decreased job satisfaction. Mackoff and Triolo (2008) further supported the impact of decreased job satisfaction in NMs and noted that new managers do not remain in their roles for long periods of time. This presents the possibility that the initial period of role transition and settling into an NM role may be so challenging that NMs may opt to leave and abandon their path of career advancement.

Recruiting and retaining skilled individuals within the NM role is imperative not only to ensure the provision of safe, high quality patient care within healthcare organizations, but also to support the retention of frontline nursing personnel (Doria, 2015). The significance of this role to the success of the health system, paired with the challenges related to retaining skilled NMs within their positions, highlights the importance of preparing and supporting future nursing leaders. The difficulty in retaining leaders in NM positions and the short tenure of many of these individuals (Mackoff & Triolo, 2008) suggests a need to focus on the initial period of role transition as new NMs move from frontline nursing to formal leadership roles. While the NM role is one that is complex, far-reaching in scope, and challenging, the early days in this position are wrought with additional challenges. New NMs must determine a new professional identity, adjust to a new set of priorities, learn an entirely new skillset, set boundaries with the teams for which they are now the leaders, and establish a leadership style that is a fit for their team and for

their larger healthcare organization – all of this is expected often without any previous formal leadership experience and without adequate training or preparation (DeCampli et al., 2010; Doria, 2015; Luo, Shen, Lou, He, & Sun, 2016; Titzer, Phillips, et al., 2013; Weinstock, 2011).

The topic of moving from frontline nursing into an NM role is one that is highly personal to me, in that I have experienced this role transition firsthand. I currently work in the capacity of NM following a successful bedside nursing career. I spent the early portion of my career working as a frontline nurse in acute care, until my career began taking an upward trajectory. I found myself moving into informal leadership roles in my clinical area, until a mentor encouraged me to strive for an NM position. While this move had never been part of the career that I had envisioned for myself, I had seen success in my previous leadership roles and saw no reason that I would not also experience similar success with this shift. The first year that I spent as an NM was shocking to me; I had no idea that a role that seemed so straightforward could be so complex, challenging, and disheartening. For the first time in my nursing career, I felt like I was failing, and that I was not good at the work that I was doing. It was difficult to adapt to a nursing career that was away from the bedside, to learn the business side of the healthcare system, and to encounter the challenges that occur when one is responsible for leading a team of nursing staff. In contemplating the evolution that occurred as I stepped away from the bedside and into my NM position, there is a day that will forever be imprinted in my memory:

*It was a Thursday morning and my boss was away for the first time since I had started in the role. It felt as if the weight of the world was on my shoulders, with no one there to answer my endless questions and to point me in the right direction. I fretted for the inevitable moment when someone would come to me with a problem for which I would not know the solution. The day began like any other, me settling into my office and checking emails, hoping that I at least*

*looked like I knew what I was doing, while my seasoned staff rolled in to work and took their places. If I was lucky, some said hello to me, while others avoided eye contact when they walked past my office. The team was standoffish and still did not know what to make of me.*

*A couple of hours had passed when one of the nurses, Barb (pseudonym) came up to me. Barb gave me one of her serious looks, let out a slight sigh, and said, "ethically I can't let this go on any longer. Sheila (pseudonym) is not here today, but we can't wait to see how long it takes you to notice. No one is looking after her assignment." I felt my stomach drop into my shoes. "Oh." It was all that I could squeak out in response. I stared at our assignment board, hoping it would tell me that I had not missed something so huge, that I had not failed to notice a missing team member. No such luck. Sheila was erroneously listed as being in that day, which I had not caught, leaving no coverage on her assignment for several hours. I felt sick, not just for the mistake, but because my team had noticed, and was testing me, waiting to see how long it would take before I noticed something that was glaringly obvious to them. I did not know whether to feel angry for being tested, hurt because I surely was not a respected part of this team, or disappointed in myself for my shortcomings.*

To me, this story illustrates the height of the difficulty that I encountered in my role transition to an NM. I was struggling to find my place in my new role, to prove that I was good at my job, and to connect with my staff. In a moment where I was wavering, and not sure that I had made the right career move, my team chose to test me rather than help me, adding to the sense of despair that I was having with the current state of my career. On occasions where I have shared this story with others, I have typically received either a sympathetic gaze, or a cringe from the listener with whom I am sharing my tale. What I did not ever expect was that I would meet another new NM that had gone through something similar. I truly felt that I was the only person

who was struggling, and that it was a deficiency in myself, rather than a common occurrence when moving along a career continuum. When I considered other leaders or managers that inspired and motivated me, I only saw them as strong, powerful, and accomplished. What I failed to see was the work that it took for them to get there, and that they likely stumbled along the way as well.

I did not expect that transitioning into an NM role would be easy, or that there would not be significant challenges along the way. However, given my previous success in my nursing career, I did not anticipate that I would feel so overwhelmed by the challenges, or that I would go so far as to question whether I had made the right choice and if I should leave the NM role. Whether the decision to persevere was born out of stubbornness or determination, I am not sure, however, I continued on in my role. Eventually, it got easier, and I settled, and found the success that seemed completely out of reach in my early days as an NM. From this experience, I developed a voracious interest in developing a better understanding of role transition when moving from frontline nursing into an NM role. Trying to uncover this knowledge, both through exploring the information and literature that currently existed about this topic, and through speaking with others that had followed similar career paths, led me to ask the research question, "how can we understand the experience of moving from frontline nursing practice to an NM role?"

In this thesis, I will explore the topic of role transition when moving from a frontline nursing role into that of an NM. To establish a firm foundation about what is already known about the experience of role transition, a literature review was conducted. Using electronic databases, scholarly research articles relevant to this topic were reviewed and discussed. This review explored the challenges experienced in role transitions specific to moving into an NM

role, the ways that NMs are prepared and supported, as well as relevant theoretical frameworks that support this topic. With the background of this topic considered and discussed, I then conducted a qualitative research study to explore the experience of NMs that have undergone this role transition. I took up hermeneutic research methodology for the purposes of answering my research question. Hermeneutics is explored in depth in the method chapter of this thesis in terms of the guiding principles of the methodology, and a discussion of notable hermeneutic thinkers, with a particular focus on the hermeneutic thought of philosopher Hans Georg Gadamer. Additionally, the specific method that was followed throughout the research process is discussed in detail. Through conducting interviews with participants that had also undergone the role transition from frontline nursing to NM, I was able to deepen my understanding of the experience. My findings are explored and included the shift in identity that accompanied the role transition, the impact of the new role on relationships, and the challenge in managing the competing priorities and expectations of the NM role. Finally, I considered how these new understandings may lend to improving the experience of role transition for future NMs, and what recommendations could be gleaned from these understandings.

## Chapter 2: Background

To develop an understanding of the experience of transitioning to an NM role from bedside nursing, it was important for me to gain a sense of what is currently known about this topic through conducting a literature review. I conducted a systematic search of the literature using the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database. The search terms used were nurse manager, new manager, orientation, training, education, job satisfaction, performance, leader, entry level, novice, preparation, transition, role transition, novice to expert, bedside nursing, succession planning, bedside nursing, formal leadership, and nurse administrator (as well as truncated versions of these search terms). While most of the articles that were included in this review came from the nursing discipline, literature focused on business and allied health fields were also considered. Only scholarly, peer-reviewed literature was included, and articles were excluded that were not published in English or that did not fit the purposes of this study, based on a scan of titles, abstract review, or reading the content of the article. I will discuss what is known about how the NM role is defined, how NMs are prepared for the role, as well as the necessary skills and challenges associated, ways that NMs may be supported throughout the transition, and the relation to the novice to expert framework.

### What is a Nurse Manager?

Westcott (2016) defined an NM as an individual who manages nurses in any area of the health system. This definition did not explicitly state that an NM must be a nurse, therefore, members of other practice disciplines could assume the NM role, dependent on organizational hiring practices. The NM role is one that is found worldwide and is present in any context where a more experienced staff member is needed to manage nurses and a care area. This role is present in the acute care, community, and private sectors of healthcare (Westcott, 2016). Given

that the NM role has such broad reach, this title may be referred to with various other names such as nurse leader (Scott & Miles, 2013; Strickler, Bohling, Kneis, O'Connor, & Yess, 2016; Weinstock, 2011; West, Smithgall, Rosler, & Winn, 2014), front-line/first-line nurse manager (FLNM) (Johansson, Porn, Theorell, & Gustafsson, 2006; Skytt, Carlsson, Ljunggren, & Engstrom, 2008), nurse administrator (Kang, Chiu, Hu, Chen, Lee, & Chang, 2012; Gardner & Gander, 1992), team manager, ward sister, ward manager, and nurse team leader (Westcott, 2016). Despite this variation, NM is the most common term found the in the literature (Conley, Branowicki, & Hanley, 2007; DeCampli et al., 2010; Djukic, Jun, Kovner, Brewer, & Fletcher, 2017; Donaher, 2007; Doria, 2015; Hsu, Lee, Fu, & Tang, 2010; Luo et al., 2016; Medland & Stern, 2009; Mackoff & Triolo, 2008; Phillips, Evans, Tooley, & Shirey, 2017; Sullivan, Bretschneider, & Causland, 2003; Titzer, Phillips, et al., 2013; Titzer, Shirey, & Hauck, 2014; Wendler, Olson-Sitki, & Prater, 2009; Westcott, 2016) and will be used throughout this study.

While the specific tasks associated with the NM role are organization specific, required competencies may include financial oversight of the budget and operating expenses, staff scheduling/rostering, management of human resource (HR) concerns, conflict resolution, workload monitoring, ensuring quality and safety of care, and patient advocacy (Canadian Nurses Association, 2009; Luo et al., 2016; Sullivan et al., 2003; Westcott, 2016). NMs are purveyors of quality in health care and are responsible for ensuring that patients and families receive care that is congruent with organizational and professional standards. This is achieved through supervision of patient care, and involvement in quality improvement projects and monitoring (Djukic et al., 2017; Johansson et al., 2006; Westcott, 2016). The level of supervision of patient care that NMs provide may vary based on setting and organizational norms. According to Johansson et al. (2006), NMs may step into a frontline nursing capacity at

times when staff shortages on a shift necessitated the taking up of these tasks. They may also be involved in the supervision of care through staying informed about what was happening on the unit and following up with complex patient situations that required NM involvement and oversight. Johansson et al. also noted less direct ways that NMs may be involved in the supervision of patient care, through communicating expectations to frontline staff, and motivating them to uphold a high standard of care. In this way, NMs possess the ability to directly influence patient outcomes, even though individuals in this role typically do not partake in direct patient care (Titzer, Phillips, et al., 2013). Business and financial acumen are increasingly important components of the NM's skillset given the resource constraints and demands for increased efficiency in the delivery of service that face health systems worldwide (Titzer, Phillips, et al., 2013). Regardless of the necessity of these skills, NMs report feeling the greatest sense of discomfort in these areas (West et al., 2014). Beyond the specific tasks associated with the role, there are also characteristics associated with successful NMs, and competencies that NMs must possess to achieve mastery in this position.

## Role Transitions, Necessary NM Competencies, and Challenges

As new NMs work through the process of transitioning from frontline nursing careers, they are striving to develop themselves into the ideal that they have envisioned for the role. Arrowsmith, Lau-Walker, Norman, and Maben (2016) described transitions as a change that caused movement from one way of being to another, taking place over time. Role transitions, or promotions, afford individuals with a sense of both personal and professional satisfaction, however, can cause a sense of initial turmoil based on changes in work tasks, leadership, role demands, and changes in professional relationships (Weinstock, 2011; West et al., 2014). Mackoff and Triolo (2008) found that successful NMs possessed several common

characteristics; their actions were driven by the mission and context of the environment that they were leading, and they did so with genuine caring and satisfaction in the work that they were doing. Successful NMs could see themselves in the work of their teams, recognizing that their leadership abilities influenced the quality of care that was provided (Mackoff & Triolo, 2008; Titzer, Phillips, et al., 2013). These NMs had a strong sense of self-awareness, and could monitor and self-regulate their emotions, navigate the change process, and demonstrate resiliency to mitigate the challenges associated with their role (Canadian Nurses Association, 2009; Luo et al., 2016; Mackoff & Triolo, 2008).

**Clinical Expertise and Communication**

Scott and Miles (2013) stated that clinical expertise was an important dimension of clinical leadership. NMs establish credibility through having a solid understanding of the work that staff are doing and the processes and policies that govern the area that they are leading. Clinical expertise also lends to the implementation of relevant quality improvement initiatives and a clear understanding of the standard of patient care in the clinical area (Scott & Miles, 2013). Luo et al. (2016) found that communication skills were of great importance in enabling NMs to be successful in their duties, allowing NMs to connect with their team, express their priorities, and engage with relevant stakeholders (Canadian Nurses Association, 2009; Doria, 2015; Johansson et al., 2006). Communication is an important tool in developing influence and enables NMs to communicate their vision and goals to their teams. Being able to express this in a way that is meaningful to frontline staff and higher-level management enables the creation of shared goals and an increased likelihood that the NM will be able to achieve these objectives with the buy-in of their stakeholders (Johansson et al., 2006; Scott & Miles, 2013; West et al., 2014).

**Navigating Organizational Politics**

Gardner and Gander (1992) and Cauthorne Lindstrom and Tracy (2001) cited the importance of NMs learning to navigate the organizational political landscape. The process of decision-making within the NM role is tenuous, and involves consideration of how choices may impact staff, patients, and the larger organization. Choosing to set priorities and become involved in projects that enhance the organization is demonstrative of strong political awareness (Cauthorne Lindstrom & Tracey, 2001). Furthermore, NMs must ensure that they have developed relationships with higher-level leadership to provide the necessary operational support that these decisions may require to be followed through (Doria, 2015; Luo et al., 2016). New NMs must develop an understanding of the organizational culture, processes, and structures of which they are a part, and ensure that they understand the values and work ethic of higher-level leadership (Gardner & Gander, 1992; Scott & Miles, 2013). Being able to reciprocate this value set enables NMs to build relationships with their leaders and establish the trust that will be required to garner support for their actions. The political landscape is largely determined by organizational priorities, and an individual's awareness of these things is necessary for successful functioning within the organization (Cauthorne Lindstrom & Tracy, 2001).

**Challenges of the NM Role**

Reaching a point of managerial competency does not come without significant challenges for NMs experiencing this transition. Even seasoned nurses that change roles are subject to experience stress associated with the upheaval of role transitions (Weinstock, 2011). This unease may be related to trying to establish a new professional identity while simultaneously adapting to the changes to the new NM's social systems, work place, and responsibilities (Arrowsmith et al., 2016). While NMs frequently cited discomfort in grasping tangible skills

such as financial mastery and addressing HR issues (West et al., 2014), the soft skills of the NM hold equal weight in reaching competence within the role. New NMs have high expectations of immediate success, and often suffer disappointment if they do not immediately meet the standards they have set for themselves (Weinstock, 2011).

**Boundaries and Expectations**

For NMs that are promoted from within an area where they previously worked as frontline staff, they must re-establish boundaries with their former teammates, while simultaneously enduring resentment from others that may have also been vying for the role, and coping with loneliness from shifts in working relationships (DeCampli et al., 2010; Doria, 2015; Gardner & Gander, 1992; Weinstock, 2011). NMs that are not only new to their role but also new to the area where they are working must strive to become an expert in a field that they previously knew little to nothing about. At the same time, they must overcome skepticism that others may hold in their abilities and go through a period of proving themselves to a team of nurses that are already clinically well-versed in that environment (DeCampli et al., 2010; Doria, 2015). NMs who were previously strong clinical performers on the frontlines may face feelings of no longer being the expert they once were and must often learn their new roles with limited organizational support.

**Shifting Professional Identity**

The nursing profession is not closely tied to notions of administration and management; not only is it rare that new nursing graduates transition into the profession with future ambitions of sitting behind a desk, the public is also not accustomed to seeing the NM role as being connected to the nursing profession (Scott & Miles, 2013). Johansson et al. (2006) described the tension that can exist in a new NM's shifting professional identify. Rather than seeing oneself as

being a nurse, whose primary goals are with patients and meeting the tasks required of the clinical area, they must begin to see themselves as leaders and administrators. Although leadership is an important competency for all nurses to possess (Scott & Miles, 2013), NMs who have taken on this competency in a formal capacity may feel disconnected from their identity as a nurse as they move along the trajectory of a career in formal leadership.

Satisfaction is no longer a result of patient care and "nursing" tasks, but rather from applying leadership skills and understanding of the administrative aspects of the role (Johansson et al., 2006). Examples of such successful NM accomplishments could include positive interactions with patients and families, mentoring staff and seeing associated professional development, influencing outcomes in the clinical area, and helping to find solutions to complex problems (Johansson et al., 2006; Sullivan et al., 2003). Mackoff and Triolo (2008) stated the importance of helping NMs to keep their view on their impact on patient care to enhance job satisfaction. All of these challenges contribute to decreased job satisfaction, which in turn may cause increases in NM turnover and poorer organizational outcomes (Djukic et al., 2017). NMs that were provided with structured management orientation programs consistently evaluated such programs positively, reported feeling more comfortable in their role, and reported feeling dedicated to leadership growth within the organization. Quality indicators further supported these positive outcomes, showing increased staff satisfaction and retention (Strickler et al., 2016).

## Succession Planning

Succession planning describes a strategic method of identifying and developing skills in individuals that demonstrate leadership potential with the intention of having them move into a formal leadership position (Phillips et al., 2017). Succession planning is not merely a means of

replacing a future vacancy, it ensures that the leaders of tomorrow are nurtured and supported, and should be a component of a thriving organization's culture (Canadian Nurses Association, 2003). Although this tactic may seem like an obvious and logical means of an organization ensuring a continuous supply of capable leaders, there is an inherent lack of strategic succession planning in the way that most NMs find themselves stepping into a formal leadership role (Doria, 2015; Titzer, Phillips, et al., 2013). Rather than identifying, preparing, and supporting nurses that demonstrate the potential to be successful in leadership positions, NMs are selected based on clinical skills or seniority (Doria, 2015; Titzer, Phillips, et al., 2013). Likewise, there is a lack of a consistent definition of leadership within the nursing profession, which may help to explain the lack of consistency in educating nurse leaders (Scott & Miles, 2013). Phillips et al. (2017) found that while 71% of healthcare organizations have systems for identifying future leaders, less than 30% of those organizations had formal leadership development programs or succession planning strategies.

Nurses that demonstrate clinical expertise or have high seniority in their area of practice are often promoted into NM roles regardless of whether they have the formal leadership skills necessary to be successful (DeCampli et al., 2010; Doria, 2015; Titzer, Phillips, et al., 2013). While there are some individuals that proactively seek this career trajectory, there are many that simply find themselves advancing in their roles without ever planning to do so (Doria, 2015). This lack of intentional advancement may lend an explanation to the lack of preparation that new NMs have for their roles. If an individual was not planning to be an NM, the likelihood increases that he or she has not spent time developing in the areas that will enable him or her to be successful in a formal leadership capacity. The skillset required for success in an NM role is one that is not easily acquired at the frontlines of nursing, encompassing things like emotional

and cultural sensitivity, financial aptitude, and strong communication and conflict resolution skills (Titzer, Phillips, et al., 2013).

## Preparation for the NM Role

NMs often do not have the academic preparation that would lend to them being qualified in their role (Luo et al., 2016) and while formal education through a master's program would support this need, it is also important for leaders to be able to understand and meet the needs of their specific organizations (West et al., 2014). West et al. (2014) did not state a specific program of graduate studies that would lend to success in this role, only the importance of the pursuit of this additional level of education. This implies the requirement for organizations to support even the most intrinsically motivated and self-directed potential leaders to achieve success. Scott and Miles (2013) argued that leadership ability is acquired over the course of an individuals' life; while it may be possible to teach the theory and skills of leadership, an individual's ability to lead may be influenced by non-educational factors such as the way that they were influenced by parental figures, exposure to leadership roles, and previous professional and academic opportunities. Individuals that are confident in their capacity to lead are more likely to seek the experiences necessary to develop these skills (Scott & Miles, 2013).

Strickler et al. (2016) highlighted the importance of providing support and development opportunities to new NMs, thereby enabling them to be as successful in NM roles as they were in frontline nursing. Although promotion to an NM role can provide a sense of personal and professional accomplishment, there is often an initial period of uncertainty and stress related to new tasks requiring completion, understanding the organizational hierarchy, the political nature of leadership roles, and significant shifts in relationships that accompany this change (Weinstock, 2011). A targeted and strategic approach to succession planning is necessary to

support the successful transition of frontline nursing staff into NM roles. The implementation of succession planning initiatives would help to create a supply of skilled and motivated leaders and create a more seamless transition for these individuals as they step into their new positions (Canadian Nurses Association, 2003; Doria, 2015; Luo et al., 2016; Strickler et al., 2016; Titzer, Phillips, et al., 2013; West et al., 2014; Westcott, 2016).

Methods of preparing new NMs must include formal education, informal support, and be responsive to feedback from both those currently in the role and those that have previously received such training (DeCampli et al., 2010; Doria, 2015; West et al., 2014). Organizational barriers towards targeted succession planning include the resources that would be required to develop and implement NM training programs, as well as credence from senior leaders, who may not understand the value and importance of preparing a future generation of leaders (Mackoff & Triolo, 2008; Titzer, Phillips, et al., 2013; Weinstock, 2011). Doria (2015) reported that most current succession planning initiatives are at the executive level. While the existence of such initiatives in itself is positive, the same emphasis on succession planning for executive leaders is not seen for those in lower and mid-level leadership positions (Doria, 2015).

**Benefits of Investing in NM Preparation**

Phillips et al. (2017) found that organizations that made an investment in succession planning saw a financial benefit from doing so. The authors stated that the benefits of investing in the development of new and potential NMs included increased staff nurse morale and retention, decreased turnover, stability in leadership staff, and increased job satisfaction (Doria, 2015; Phillips et al., 2017). Decreasing turnover in NMs is important because it fosters consistency and stability for those in leadership roles and is also pragmatic from a financial perspective. The cost of replacing an NM, including recruiting and training expenses, is

estimated to be anywhere from 75% to 125% of an annual NM salary (Phillips et al., 2017). To examine this cost from the perspective of an NM working for Alberta Health Services (AHS) (the main health system in Alberta, Canada), this would represent an expense of approximately $77,000 to $129,000. Another expense associated with NM turnover is the time that the organization or clinical area must cope with not having an active leader. Succession planning demonstrates organizational commitment, an investment in the future, and is a proactive modality for creating a pipeline of well-prepared NMs in the future (Doria, 2015; Phillips et al., 2017; Strickler et al., 2016; Titzer, Phillips, et al., 2013).

## Stages of Role Transitions

In seeking to understand the experience of transitioning to an NM role, one must consider how long it takes to complete this transition, and the associated stages of this transition. Weinstock (2011) and Doria (2015) acknowledged that there is a common expectation that new NMs be well situated in the role within 100 days. Weinstock added that such an expectation is a myth, and it realistically takes most new leaders a year to fully understand the complexities and expectations of their role, build relationships with key stakeholders, and learn to balance the unique politics of their organization. While not otherwise specifically addressed, the literature does support transitioning into an NM role taking longer than 100 days as other management training programs that were detailed were for durations of four months, six months, and a full year (DeCampli et al., 2010; Strickler et al., 2016; West et al., 2016).

Luo et al. (2016), using a phenomenological approach, described four main phases in becoming an NM: the adaptive phase, the running-in and stable phase, the stagnation phase, and the maturation phase. There was no time frame assigned to each phase, nor was there an explanation of how long it took to progress to a point of excellence in the NM role, beyond

stating that the time that it took to do so was substantial (Luo et al., 2016). The authors of this study also noted that not all NMs were able to overcome the stagnation phase, however, did not elaborate on what this implied in terms of a professional outcome, other than stating that such individuals may plateau in this stage and lack future ambition toward nursing leadership roles (Luo et al., 2016).

**The Adaptive Phase**

In this phase, new NMs became keenly aware of the complex duties that they had assumed and the lack of management knowledge that they currently possessed (Luo et al., 2016). NMs in this phase of transition lacked experience and built competency through a process of trial and error, however also demonstrated high levels of organizational commitment and dedication to adjusting to their new roles. Of note, Luo et al. (2016) stated that the result of learning through trial and error was often feelings of failure, which is in direct conflict with the expectations of immediate success and tendency towards perfectionism noted by Weinstock (2011). DeCampli et al. (2010) noted that areas that may be particularly challenging to new NMs included financial management, managing new technology, and building relationships with key stakeholders in their area. Luo et al. stated agreement with this and found that while communication was the most challenging skill for NMs to master, it was a determinant of the NM's success in the role. In this phase, the NM must also develop or prove clinical expertise to quell the skepticism that the team they are managing may have about their ability to supervise the area (Doria, 2015; Luo et al., 2016).

**The Running-in and Stable Phase**

In this phase, NMs began to realize and acquire the management competencies that were necessary for them to be successful in their role. NMs in this phase also demonstrated self-

awareness and reflected on their strengths and weaknesses to ensure success within the role (Luo et al., 2016). Mackoff and Triolo (2008) described new NMs experiencing "identification" and being able to recognize positive clinical outcomes from the work that they were doing, as well as "reflection" and "self-regulation," in which NMs learned through experience and could control their reactions and emotions to manage challenges within their teams. At this point, NMs became aware of their responsibility towards ensuring that safety and high-quality patient care were present within their clinical areas (Luo et al, 2016). NMs also realized the necessity of establishing relationships with their staff and with their higher-level leadership. As these relationships were established, NMs became aware of the expectations of their supervisors, reflecting on and adapting their practice to ensure satisfaction in the work they are doing (Luo et al., 2016). Weinstock (2011) described these markers as being indicative of developing leadership consciousness, developing the ability to think strategically, solve problems, and maintain the values and mission of the organization.

**The Stagnation Phase**

In this phase of the transition, NMs often felt overwhelmed with their new set of responsibilities and workload. NMs in this phase felt a lack of motivation and a sense of ambivalence towards future career advancement (Luo et al., 2016). According to Mackoff and Triolo (2008), feelings of dissatisfaction and lack of engagement in the NM role could lead to attrition and turnover. West et al. (2014) suggested that NM turnover in the next 10 to 15 years may be as high as 30%, highlighting the importance of ensuring that potential leaders are supported in developing the resiliency and coping skills necessary to meet the demands of their positions and be retained in their roles (Doria, 2015; Mackoff & Triolo, 2008; Westcott, 2016). The stagnation phase supports the stressful nature of this role, with some of the main stressors

being lack of role clarity, overwhelming workloads, and competing priorities. The mounting weight of these challenges can lead to emotional distress, a lack of work-life balance, and decreased levels of job satisfaction (Luo et al., 2016; Westcott, 2016).

### The Maturation Phase

The final phase details a period where NMs are able to overcome the challenges associated with their new positions and begin to develop their own professional identity (Luo et al., 2016). Rather than focusing on the individual tasks for which they are responsible, NMs began to take a systems-level approach to their way of thinking and management approach. Here, NMs were able to realize their own unique professional identity, and had developed a sense of comfort and instinct in their practice (Benner, 1982; Luo et al., 2016) The implementation of strategic succession planning initiatives and a structured, standardized new NM curriculum would help to ensure that individuals in these roles are able to advance to the maturation phase and experience a smoother period of transition as they enter formal leadership positions (Luo et al., 2016; Titzer, Phillips, et al., 2013). Not only is the lack of standard preparation a challenge in ensuring that new NMs reach a point of maturation, there is also a lack of benchmarking across existing management and leadership development programs to ensure the consistency and quality of content that is delivered (Westcott, 2016). DeCampli et al. (2010) found that even once settled in their role and having entered the maturation phase, NMs required long-term mentorship and support throughout their career.

## Coaching and Mentoring in Role Transition

The support provided through coaching and mentorship was noted to be important throughout the transition into an NM role and a component of strategic succession planning (DeCampli et al., 2010; Luo et al., 2016; Strickler et al., 2016; Titzer, Phillips, et al., 2013;

Weinstock, 2011; West et al., 2014; Westcott, 2016). There was a greater emphasis placed upon coaching than on mentorship in the literature, and while the terms coaching and mentorship are often used interchangeably, it was noted that these terms describe different relationships. DeCampli et al. (2010) stated that coaching denotes a more formal relationship in which the coach is not selected by the learner. The purpose of the relationship is to foster the development of the learner, and not to establish a personal friendship. Mentorship, on the other hand, is a relationship in which members self-select each other and tends to be a long-lasting connection. Cauthorne Lindstrom and Tracy (2001) described a mentorship relationship as being personal in nature and based on a mutual interest in support and development. They found that the quality of this personal relationship was a determinant of the success of the mentorship experience. In instances where coaching relationships were very long-lasting, the relationship could transition to one of mentorship, bridging between professional and personal (DeCampli et al., 2010).

DeCampli et al. (2010) and Weinstock (2011) further described a coaching relationship as being a process in which the development needs of the learner are assessed, a coaching plan is made and put forth into action, and the progress of the learner is reviewed and evaluated through the provision of feedback from the involved parties. Beyond the provision of support and guidance offered in a mentoring relationship, coaching sets a clear goal and plan for attaining stated objectives and has been identified as a means of ensuring long-term success within healthcare organizations (Weinstock, 2011). A coaching or mentoring relationship has the additional benefit of providing a role preview for the mentee; the mentor/coach may be able to provide a realistic picture of their role for the mentee/coachee who may require support not only in their current position, but in developing a future career trajectory (Cauthorne Lindstrom & Tracy, 2001). The benefits of these relationships allow the NM that is being coached or

mentored to better understand his or her role, demonstrate increased self-awareness, experience improved job satisfaction, and enhance his or her leadership or management style to suit the needs and culture of the environment and organization (Westcott, 2016). In turn, positive organizational outcomes such as improved quality indicators, staff engagement, and decreased turnover may also be attained (Phillips et al., 2017; Strickler et al., 2016; Westcott, 2016).

Incorporating coaching and mentorship into the transition into NM roles must be deliberate and prioritized by healthcare organizations as a method of investing in the leadership potential of nurses entering these positions (Canadian Nurses Association, 2003; Doria, 2015; Luo et al., 2016; Titzer, Phillips, et al., 2013; Strickler et al., 2016; West et al., 2014; Westcott, 2016). For coach-learner pairings to be successful, it is important that the coach share the learner's ethics and values, but be external to the learner's immediate work area to ensure the confidential nature of the relationship (DeCampli et al., 2010; Westcott, 2016). In this way, the coach can provide a valuable, unbiased perspective and help the learner navigate the complex issues within their role, without the fear of scrutiny that could accompany being coached by an immediate supervisor. Coaching enables NMs the opportunity to develop increased self-awareness and understanding of their new roles, and to learn transformational leadership, resiliency, and adaptability (Westcott, 2016). NMs that were coached not only perceived themselves to possess increased management abilities, they experienced improved relationships with their teams and colleagues, enhanced job satisfaction, and were able to translate what they learned from their coaches into improved outcomes in patient care and quality outcomes (Westcott, 2016). Beyond making NMs more comfortable in their roles and providing support from someone else that has "been there," coaching has the potential to translate into improved

organizational outcomes, greater management potential, staff satisfaction, and overall cost savings (Doria, 2015; Strickler et al., 2016; Westcott, 2016).

## Novice to Expert

In exploring the experience of transitioning from a frontline nurse to an NM, Benner's theory of novice to expert (1984) was frequently cited, particularly in literature that examined the ways that new NMs are evaluated and prepared for their roles (Abraham, 2011; Donaher et al., 2007; Titzer, Shirey, et al., 2014). This theory was adapted from the Dreyfus model of skill acquisition, which suggested that in the process of developing a skill, an individual goes through five different levels of proficiency: novice, advanced beginner, competent, proficient, and expert (Benner, 1984). Benner applied this model to nurses at different points in their careers, including nursing students, new graduates, and experienced nurse clinicians. She looked at ways that nurses at different points in their careers provided care, made decisions, applied clinical judgment, and learned. Benner argued that the practice of expert nurses was holistic rather than procedural and was often based heavily on intuition and past experiences (Benner, 1982). Novice nurses, on the other hand, relied heavily on the objective attributes of a situation, and needed rules and guidelines to inform their actions; they did not have experience that they could call upon to apply discretionary judgment (Davis & Maisano, 2016). As an individual progressed through each stage of proficiency, their practice became more instinctive and based on acquired nursing knowledge and experience, rather than prescriptive steps or guidelines (Benner, 1982). Benner's theory explored role transition, as novice to expert looked at the changes that nurses went through during their careers, and how they developed within the profession.

Benner's theory is a natural fit as a framework for understanding role transition; as previously noted, expert nurses, or those that demonstrate clinical aptitude or seniority, are promoted to NM roles, despite not necessarily having demonstrated management capability (DeCampli et al., 2010; Doria, 2015; Titzer, Phillips, et al., 2013). This role transition relegates expert nurses back to a novice role as a new NM. The experience of moving from novice to expert as must be relived as the novice NM learns the skills and instincts that are necessary to once again advance his or her practice to what may be considered an expert level. An important consideration is that while Benner's theory suggests a linear progression when moving from novice to expert, new NMs may not follow such a predictable trajectory; some individuals may take more time to develop expertise than others and may spend more time in certain phases of proficiency than others. Weinstock (2011) recognized that the regression back to novice status can disrupt the confidence and success that enabled the new NM to obtain his or her new role. Donaher et al. (2007) used the novice to expert theory to inform their research on NM skills because they believed that NM skills are acquired through practice and movement through the novice to expert continuum. Titzer, Shirey, et al. (2014) found that Benner's novice to expert reinforced the non-linear nature of leadership development and the acquisition of skill necessary for success in the NM role. Individuals going through the transition from bedside nurse to NM move through each stage of the continuum at their own pace, which is dependent on their specific situation and individual skill level (Titzer, Shirey, et al., 2014).

The lack of succession planning associated with the role transition from expert nurse to novice NM may be tied to the belief that the skills that a strong nurse has will automatically translate to the new role. However, the skills that are necessary to be successful as an NM, such as the management of HR concerns, understanding the financial aspects of supporting a clinical

area, comfort in conflict resolution, managing difficult personalities, and possessing a clear understanding of organizational goals and priorities (Titzer, Phillips, et al., 2013; West et al., 2014) often do not come with structured training and support. Benner (1982) found that it was is not possible to define the practice of an expert nurse in a series of formal steps or facts, rather it is the addition of experience that lends to a deep understanding of an experience and knowledge of how to successfully approach challenges that are encountered (Benner, 1982). Abraham (2011) mirrored these sentiments, and further stated that leadership skills cannot be acquired through instructing NMs on how to do their job, they must encounter new situations and challenges and work through them to cultivate these abilities. The application of Benner's novice to expert theory to the experience of NM role transition supports the need for succession planning to help individuals acquire the skills necessary to move through each step in the framework (Benner, 1982; Titzer, Shirey, et al., 2014).

## Understanding the Transition into an NM Role

The NM role is one that is vital to the successful operation of the health care system, spanning a vast terrain of complexities and challenges that must be carefully traversed to maintain quality patient care, staff engagement, and meet organizational priorities and expectations. The available literature supports a sound argument as to the significance of the NM role, the complexity of making the transition from frontline nursing to management, and the ways that future leaders can best be trained and supported in their professional development. The information that is available about the experience of transitioning from a frontline nurse to an NM role furthers understanding in terms of explaining the role, the ways that NMs are currently prepared, and the identified need for more strategic succession planning by organizations. Additionally, challenges of the NM role are explored, and we are provided with a

theoretical framework to help guide our thinking and understanding. While this information tells us a great deal, there are parts of the experience of moving from frontline nursing to an NM role that are not captured, and which support the importance and relevance of my research. In the forthcoming chapter, I will explain what the available literature fails to tell us about the experience of role transition, and how I will go about bridging this gap in understanding.

## Chapter 3: Research Method and Methodology

The purpose of this study is to answer the research question, "how can we understand the experience of transitioning from frontline nursing to an NM role?" Through endeavoring to answer this question, I hope to fill in the gaps of understanding that currently exist. While the literature about role transition from frontline to NM is informative and the phases and associated challenges of the experience are well articulated, it is often presented as a linear process, yet this neglects a significant part of the story. It does not explain moments like the one I described in the first chapter or warn future leaders that there will be days that can only be described as soul-crushing. Entering the role equipped with a richer understanding of the experience may provide the opportunity for new NMs to normalize their struggles, and work through the growth and development necessary to ultimately achieve success and comfort within the role. NMs experiencing this role transition may perceive their personal challenges as a sign of weakness or failure, rather than as an element of the experience that many NMs have also encountered. Through speaking with NMs that have personally undergone this transition, and interpreting the content of those conversations, I was able to cultivate and disseminate an understanding of the experience that can be provided to nurses that are considering the pursuit of a career as an NM, or those that are in the process of undergoing that transition.

Embarking upon a career shift towards formal leadership knowing not just that the experience will be challenging, but also being aware of the experiences of others within a similar context is invaluable. While many new NMs anticipate that they may not be fully prepared for their role by their organization, they may not be aware of how this may make them feel, and how it may impact their confidence and professional identity. My hope is that through gaining this understanding, individuals that undertake this role transition in the future may endure long

enough to make it past the toughest aspects of the experience. Answering this research question required a qualitative research design. A qualitative approach was the most reasonable and effective way to do this because I was seeking to understand the experience of individuals in a particular situation and required the rich description and understanding that qualitative research provided (Flick, 2009). Aspects of an individual's role transition from frontline nursing to that of an NM are complex, deal with human emotion, and could vary based on context. It would be difficult to quantify these aspects or place them into rigid categories, again denoting the appropriateness of a qualitative approach (Polkinghorne, 2005). Qualitative research is a broad categorization, and in order to conduct my research, I had to determine the specific methodology that would best enable me to answer my research question. Hermeneutics is a qualitative methodology concerned with understanding and interpretation and is the specific methodology that I used to answer my research question. I will further explore the methodology of hermeneutics, the notable philosophers of this methodology with a focus on Gadamerian hermeneutics, and describe the research design and interpretive process that was followed.

## Hermeneutics

The origins of the term hermeneutics come from the ancient Greek word hermeneuein, meaning to say, explain, or translate, and was first used to describe how divine messages and thoughts were expressed through language (Moules, McCaffrey, Field, & Laing, 2015; Zimmerman, 2015). The philosopher, Aristotle, authored the first written work addressing hermeneutics, where he discussed how spoken and written words could be used to express thoughts (Zimmerman, 2015). The Greek god, Hermes, is often associated with hermeneutics; a calculating trickster, Hermes delivered divine messages to mortals (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). Hermes was known for delivering messages from the gods in ways

that were complicated, playful, and unclear, necessitating the use of interpretation to decipher his difficult communications (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). Zimmerman (2015) stated that Hermes demonstrated that interpretation is comprised of two parts: receiving the message (understanding) and being able to communicate your message to others in a discernible way (being understood). The practice of hermeneutics as textual interpretation dates as far back as the 17th century and evolved philosophically during the 19th and 20th centuries (Moules, McCaffrey, et al., 2015).

Hermeneutics as a methodology is one that is often linked to phenomenology, which, simply stated, is a method used to study experiences or phenomena. However, despite this association, it is important to note that hermeneutics and phenomenology are not the same thing. Phenomenology seeks to define an experience and establish a sense of truth, drilling down to the core and finding the essence of the experience (Moules, 2002; Moules, Field, McCaffrey, & Laing, 2014). Hermeneutics, however, has a different focus; rather than defining and essentializing a topic, hermeneutics maintains the complexity of the subject matter, keeping it alive, and continuing the process of inquiry around it (Moules, 2002; Moules, Field, et al., 2014). As such, the hermeneutic notion of truth may differ from that of other methodologies. Hermeneutic research is not used to try and establish a singular, objective truth that is preserved and unwavering over time. Rather, hermeneutics takes the viewpoint that truth exists based on context, and what is true at one place and time may not be true at another (Moules, Field, et al., 2014). Truth in hermeneutics is not a singular entity, and this method embraces the possibility that there are many truths. Zimmerman (2015) clarified that despite this, hermeneutics is not a relativist practice as interpretations are not just subjective, they are based on concrete aspects of the phenomena in question. Truth in hermeneutics is revealed as we develop understanding

through interpretation, but it is concealed as this new understanding gives way to new questions and complexities (Moules, Field, et al., 2014).

Gadamer (1984) described hermeneutics as the science and art of interpretation. Similarly, Moules (2002) defined hermeneutics as a tradition of interpretation, and a process of reflective inquiry that involves an understanding of the whole world. Zimmerman (2015) also described hermeneutics as being heavily tied to interpretation, however, stated that interpretation could take both overt and less obvious forms. While there are certainly instances in which we consciously interpret and look for meaning, humans also interpret constantly without realizing that they are doing it. Zimmerman posed the question of whether interpretation is only needed in instances where there is a lack of understanding. For instance, if a person sees a red traffic light and stops their vehicle, was it an interpretation that caused them to take this action? Zimmerman stated that hermeneutics is, in fact, more than making sense when an obvious explanation is not apparent:

> Hermeneutics is the art of understanding and making oneself understood…one is engaged in hermeneutics whenever one tries to grasp the meaning of something - be it a conversation, a newspaper article, a Shakespeare play, or an account of past events. (p.2)

Hermeneutic interpretation provides an understanding through working through the facts about something to develop meaningful knowledge and familiarity with the topic (Zimmerman, 2015).

Defining hermeneutics as a methodology is challenging because at its very essence, hermeneutics resists definition and being reduced to a singular truth (Moules, McCaffrey, et al., 2015). While there is agreement that hermeneutics is the art of interpretation, Zimmerman (2015) posited that hermeneutics is also a means through which understanding is established. Understanding is established based on the language, culture, and time in which an individual

exists, and is a matter of integrating words, text, facts, and experiences within these conditions. In establishing understanding through interpretation, hermeneutics is heavily reliant on language (Moules, 2002; Moules, McCaffrey, et al., 2015; Zimmerman, 2015). Polkinghorne (2005) recognized the importance of language as being the medium through which people can transform their experiences into words, and what enables us to access the experiences of others. In its attentiveness to language, hermeneutics contemplates not only the things that are said, but also the things that are more implicit and have not been said (Gadamer, 1989; Moules, 2002). Moules, McCaffrey, et al. (2015) stated that in the practice of hermeneutics, a silence can be more telling than the words that a person is speaking; the words that are missing have the potential to demonstrate a great deal to the researcher based on the context within which the conversation exists.

The practice of hermeneutics and establishing understanding through interpretation is a process of ongoing concealment and unconcealment (Moules, McCaffrey, et al., 2015). The notion of concealment and unconcealment is also known as aletheia, which occurs both when something is revealed that was not previously known, or when something is forgotten that was once known (Moules, McCaffrey, et al., 2015). Through establishing a new understanding of a topic, the act of unconcealing occurs, however, the new understanding that has been established may replace, or hide, a previous understanding or belief about the same topic. Moules, Field, et al. (2014) discussed the example of the clay bowl in explaining the notion of aletheia. When looking at a clay bowl sitting on a table, one is only able to see one aspect of the bowl. To see the other side of this bowl, an individual must move around to the other side of the table, however, through this movement and changing of perspectives, the original view of the bowl is lost. The only way that it would be possible to see the entire bowl at once would be to break it

into pieces, however, this destroys the integrity of the structure, rendering it to be broken pieces and not a bowl at all (Moules, McCaffrey, et al., 2015). In this way, hermeneutics shows us certain things while holding back others. Just as hermeneutics does not seek an absolute truth or definition, we cannot aspire to know everything about a topic if we are to maintain the topic as a whole and not reduce it to separate parts (Moules, Field, et al., 2014; Zimmerman, 2015).

A challenge associated with hermeneutics is translating the art of interpretation, understanding, and aletheia into practice. With the importance that hermeneutics places upon language, it is a natural fit that understanding should be generated through dialogue and conversation between the researcher and participant. Hermeneutics also does well to answer questions about relationships, based on the associated emphasis on understanding and conversation (McCaffrey & Moules, 2016). Hermeneutics recognizes the complexity of relationships, and stresses the importance of establishing genuine conversation, that recognizes the context, power dynamics, said and unsaid words between researcher and participant in obtaining a true and deep understanding (McCaffrey & Moules, 2016). Technically, a research interview cannot be considered a genuine conversation because the researcher and participant have clearly defined roles, however, it is still possible for the researcher to remain open to viewpoint of the other (G. McCaffrey, personal communication, November 18, 2018; Moules, McCaffrey, et al., 2015).

The act of conducting hermeneutic research is guided by the topic and not by a prescriptive research method. Participants are recruited who will best inform the topic that has addressed the researcher, data takes the form that best contributes to understanding, and analysis is a matter of looking at the parts and then at the whole and back again – there are no prescriptive recruitment strategies, methods of data collection, or thematic analyses to be had (McCaffrey &

Moules, 2016; Moules, McCaffrey, et al., 2015). Although there is not a strict method associated with conducting hermeneutic research, this does not mean that the researcher may proceed haphazardly in his or her quest for understanding of a topic (Moules, McCaffrey, et al., 2015). Rather, being methodical in conducting hermeneutic research demands that the researcher is always attentive to the topic, asking questions and seeking data that leads him or her closer to understanding. It is incumbent upon the researcher to make the topic as compelling to others as it was when he or she first received the address, and to be able to engage participants in a conversation that allows the researcher to explore the full complexity of the topic (Moules, McCaffrey, et al., 2015). The researcher must be dedicated to the topic, while at the same time, self-aware of where he or she sits in relation to the topic. The researcher must acknowledge his or her own biases and be aware of how they may influence the dialogue, while simultaneously being able to set these aside should the topic dictate and draw the conversation elsewhere when needed (Moules, McCaffrey, et al., 2015).

## Notable Philosophers of Hermeneutics

The practice of hermeneutics is one that has evolved over the ages, and, likewise, is one that has been the subject of considerable philosophical thought and discussion. To fully appreciate this methodology, one must give heed to the philosophers that have shaped modern hermeneutic thought. Some of the most notable hermeneutic thinkers included Schleiermacher, Dilthey, and Heidegger. Husserl, while not a hermeneutic philosopher, was influential in Heidegger's and Gadamer's development of hermeneutics through his work in phenomenology (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). A discussion of influential philosophers of hermeneutics would be incomplete without a more comprehensive exploration of Gadamer, whose brand of hermeneutics is that which was taken up for this research.

**Fredrich Schleiermacher**

Fredrich Schleiermacher is considered by some to be the driving force behind modern hermeneutics, and focused on establishing a basic, universal approach to this methodology (Moules, 2002; Moules, McCaffrey, et al., 2015). He established hermeneutics as being philosophical in nature based on the relationship that he saw between speaking and understanding. Schleiermacher saw speaking as being the verbalization of thoughts, making hermeneutics a part of thinking, and therefore, a philosophical practice (Moules, McCaffrey, et al., 2015). Language was important, and Schleiermacher saw the application of language, either spoken or written, towards being able to understand and make oneself understood as an important part of hermeneutics (Zimmerman, 2015). Like Hermes, Schleiermacher recognized that there were two parts of understanding in humans: expressing your thoughts in order to make yourself understood and being able to receive the message and understand the thoughts of others (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). Given the importance placed upon language, Schleiermacher also identified conversation and relationships through dialogue to be an essential component of hermeneutic practice (Moules, McCaffrey, et al., 2015).

Schleiermacher's belief was that thoughts could only be expressed through language; therefore, the practice of interpretation was not possible without the skilled application of language (Zimmerman, 2015). He believed that the correct methodical application of hermeneutics would lead to the correct interpretation (Moules, 2002). While Schleiermacher recognized the importance of understanding in hermeneutics, he believed that the starting point for the practice of this methodology was misunderstanding. The identification of a source of misunderstanding served as the impetus for hermeneutic inquiry, and the way to overcome misunderstanding was through shared points of view with others through a dialogical exchange

(Moules, McCaffrey, et al., 2015). One of the greatest marks that Schleiermacher left on hermeneutics was his idea of the hermeneutic circle, moving between the whole and the parts when interpreting (Moules, 2002).

**Wilhelm Dilthey**

Wilhelm Dilthey focused on two main points in his work with hermeneutics: the idea of historicism, and the problem of method (Moules, McCaffrey, et al., 2015). Historicism meant that understanding was heavily dependent on the context in which something took place – the understanding that exists at one point in time might not hold true in another (Moules, McCaffrey, et al., 2015). Other thinkers struggled with the notion of historicism, in that it was difficult to establish an objective truth if this truth was dependent on the context within which it existed. Dilthey articulated the differences between the natural sciences and human sciences, seeing the application of the natural sciences as being a way to explain, whereas the human sciences were applied to understand (Moules, McCaffrey, et al., 2015). Dilthey attempted to explain the method of carrying out the human sciences as being focused on the systematic relationship between lived experience, expression, and understanding (Moules, McCaffrey, et al., 2015). Dilthey's notion of understanding moved beyond the commonly accepted definition of attaining cognitive comprehension of facts to being able to assign meaning to the things that are encountered based upon lived experiences (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). He believed that understanding was not something that occurred based on explanation and conceptualization, but that it was an integral part of human existence, and therefore, also held philosophical importance (Moules, 2002; Zimmerman, 2015).

**Edmund Husserl**

Although the focus of Edmund Husserl's work was phenomenology and not hermeneutics, his ideas were significant in questioning the predominant belief that the natural sciences were the only source of objective truth and methodological rigor (Moules, McCaffrey, et al., 2015). Husserl demanded that attention be paid to questioning human experience and developing a sense of understanding in a way that was methodical and concrete (Moules, McCaffrey, et al., 2015). His work in phenomenology was particularly focused on human knowing, and the ways in which perception, memory, and imagination impacted this knowing (Moules, McCaffrey, et al., 2015). The difference in natural attitude and phenomenological attitude was also something that Husserl discussed; the natural attitude referred to our normal awareness of things that we likely take for granted, whereas phenomenological attitude referred to a systematic, intentional noticing and analyzing of phenomena (Moules, McCaffrey, et al., 2015). This also related to Husserl's ideas about the lifeworld, which referred to the way that humans take things for granted that exist around them, and do not necessarily appreciate the symbolism, history, and meaning of everyday objects (Moules, 2002; Moules, McCaffrey, et al., 2015). Husserl linked the notion of the lifeworld back to natural science, in that scientific knowledge must come from a prior understanding about the world (Moules, McCaffrey, et al., 2015).

The application of phenomenological attitude involved assessing and reducing something down to its essence or meaning. This differed from the natural sciences where this practice might mean to reduce something to its physical parts or chemical makeup (Moules, McCaffrey, et al., 2015). To engage in this kind of meaning-finding and reduction, Husserl felt that it was necessary for the thinker to bracket their previous beliefs and biases about the phenomenon that

they were trying to understand. This involved the individual acknowledging such presuppositions, and then not allowing them to impact the understanding that he or she was developing (Moules, McCaffrey, et al., 2015). Husserl's work with phenomenology provided a useful connection to hermeneutics in that it supplied a philosophically robust and rigorous procedure with which to derive understanding about the human experience (Moules, McCaffrey, et al., 2015).

**Martin Heidegger**

Martin Heidegger was a student of Husserl's who offered a divergent set of ideas than those provided by his predecessor. One way that their ideas diverged was that while Husserl saw the world as being made up of phenomena requiring definition and reduction to their essences, Heidegger saw the world as being made up of a complex set of events that are revealed to humans through their interactions with the world (Moules, 2002; Moules, McCaffrey, et al., 2015). Heidegger built upon Husserl's ideas about the "lifeworld," and used it to describe being in the world, and the type of understanding this derived from experience. The lifeworld provided a phenomenological base for Heidegger's hermeneutics (Moules, McCaffrey, et al., 2015). Heidegger did not believe in bracketing and felt that it was not possible to remove oneself from an experience or understanding. He believed that humans were in the world, and the understanding that they established was based upon their interaction with the world, not removing themselves from it (Moules, McCaffrey, et al., 2015). Language was used to create a rich and highly textured description of life as it was lived and encountered and was the medium through which people related to the world (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). Heidegger thought that understanding was something that humans did unconsciously and without effort, believing that one could not be human without interpreting (Zimmerman, 2015).

Heidegger saw that there were two worlds: the world "out there" in the objective things that exist, and the world "in here" in the subjective thoughts and experiences that exist with the mind (Moules, McCaffrey, et al., 2015). Heidegger did not believe that it was possible to separate the world out there and in here and likewise did not believe that it was possible to be either purely objective or purely subjective. It was people's state of being in the world, and our objective and subjective interpretations that allowed understanding to occur (Moules, McCaffrey, et al., 2015). According to Heidegger, there were two types of truth; truth existed in terms of being a fact that was disclosed and the type of truth that hermeneutics strived to find (Moules, McCaffrey, et al., 2015). When it came to the method of hermeneutics, Heidegger stressed that the practice of this methodology was not arbitrary, it arose from the phenomena, and was guided by the subject matter so that understanding could be established (Moules, McCaffrey, et al., 2015).

**Hans Georg-Gadamer**

Hans Georg-Gadamer is considered to be an important and influential hermeneutic philosopher, building upon previous work in the field, and placing emphasis on dialogue and the shifting understandings that are associated with this type of research (Moules, McCaffrey, et al., 2015). Within his view of science and method, Gadamer believed that the natural sciences and the associated methods and objective truth that they sought to determine were only a part of human understanding. He believed that the human sciences were also essential to establishing human meaning and understanding (Moules, McCaffrey, et al., 2015; Palmer. 2001). Gadamer thought that the objective knowledge that was most closely associated with the natural sciences failed to supply the understanding that interaction with the subject matter and human expression achieved through application of the humanities and social sciences (Palmer, 2001). Despite the

importance that Gadamer placed upon the human sciences for obtaining meaning, he did not discount the importance of being methodical, nor was he suggesting a lack of rigor associated with the social sciences (Palmer, 2001; Zimmerman, 2015).

**Understanding and language**. Gadamer suggested that understanding was infinite and that there was more than one correct understanding to be discovered. He believed that objects revealed their meanings to us in a dynamic way that was constantly changing based on how we interacted with these objects, and this influenced our understanding (Zimmerman, 2015). Establishing one way of understanding could lead to asking further questions and establishing alternate understandings (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). Gadamer argued that through seeing the viewpoint of another, one had the potential to enhance one's own understanding, and to understand ones' self in relation to the meaning of the subject matter (Palmer, 2001). The notions of language, understanding, and meaning were also closely tied. Gadamer believed that to live in a meaningful world, one must develop and communicate understanding. Language was the way that understanding was expressed, established, and interpreted (Moules, McCaffrey, et al., 2015); it is shared between people of a common context and exists within conversation (Palmer, 2001).

Related to language was the importance of conversation in conducting hermeneutic research. If human meaning was established and expressed through language, conversation was the vehicle through which these understandings were delivered to us and to others (Moules, McCaffrey, et al., 2015; Palmer, 2001). Entering into genuine conversation with another required that an individual acknowledged and accepted the point of view of the other and was willing to reframe his or her previous understanding (Palmer, 2001). Gadamer stated that understanding could only be established when people moved beyond merely hearing each other

to truly listening to what the other was saying (Palmer, 2001). People learn to orientate themselves to their surroundings and communicate through making associations between words, objects, and scenarios that they encounter, demonstrating that it is through language that the world around us is made to be meaningful (Zimmerman, 2015). While people may search for the right words to express themselves, it is not the words that they choose that allow this, rather, it is the process of communication and allowing themselves to be understood that makes this possible (Palmer, 2001). Gadamer provided a structured and purposeful definition of conversation, seeing it as an exchange that revealed new understanding where one person speaks and another person listens (Palmer, 2001).

Genuine conversations were dialogical interchanges where meaning is laid out by one individual and understood by another, however, not all conversations met this purpose and therefore, not all conversations could be considered genuine conversations (Moules, McCaffrey, et al., 2015). In genuine conversations, there is a mutuality about the flow of dialogue. Engaging in a genuine conversation with another was to acknowledge the fact that the other person could be right, and that they had the potential to show you something that you did not know previously (Palmer, 2001). Conversations in which an individual learned something new, or had to re-evaluate their understanding, were seen by Gadamer as being meaningful and valuable (Palmer, 2001). The researcher is simultaneously an active listener and an engaged and reflective questioner for the participant (Moules, McCaffrey, et al., 2015). While the researcher has a well-defined purpose for the conversation, they must not only focus on this as they are guiding the dialogue, they must also engage with their participant in the understanding that they are sharing (Moules, McCaffrey, et al., 2015).

**Context and interpretation**. Gadamerian hermeneutics pays attention to the context within which interpretation and understanding take place. Understanding is not viewed as something that we acquire, but rather as something that can be grasped only when we are engaged in it (Zimmerman, 2015). Gadamer acknowledged that one could not properly understand without considering the history that influenced a topic. In the same way things change over time, so must our understandings evolve (Moules, McCaffrey, et al., 2015). Gadamer asserted that it was not possible for researchers to set aside their history and traditions, rather, they must be evaluated and incorporated into the understandings that were established (Moules, McCaffrey, et al., 2015). Related to the importance of acknowledging context and history in our interpretation was the notion of prejudices in Gadamer's hermeneutics. We seek to understand something that already exists, and therefore, we come with pre-existing notions that will influence the understanding that is shaped by our interpretation (Moules, McCaffrey, et al., 2015). There are both positive and negative prejudices, and as such, these pre-populated notions may serve to either open us up to understanding, or they may serve to close us off, steering us in a completely different direction than the topic is leading (Moules, McCaffrey, et al., 2015; Palmer, 2001). Gadamerian hermeneutics calls for researchers to be aware of their own prejudices and reflect upon them so that when they come into play, they are aware of the influence that their prejudices may hold (Moules, McCaffrey, et al., 2015).

**Play, the hermeneutic circle, and fusion of horizons.** Some key elements of Gadamerian hermeneutics are play, the hermeneutic circle, and fusion of horizons. Play was an idea that Gadamer used to conceptualize the practice of hermeneutics, and in the epigraph to Truth and Method, a poem by Rilke referenced the image of the catcher and the thrower of a ball (Moules, McCaffrey. et al., 2015). What he meant by this was that when a person is fully

immersed in the act of play, they are taken outside of themselves, and the way that they experience the game is changed (Moules, McCaffrey, et al., 2015). To play requires that a person is fully engaged in the act, yet is fully responsive to how the game is unfolding, and the nuances that may be associated. While the way that individuals play is very much dictated by the flow of the game, it is not without rules, and is not random (Moules, McCaffrey, et al., 2015). This relates back to hermeneutics in that while the researcher must follow where the topic leads, they do not do so spuriously, and they do not let the conversation take them down a path that does not serve the topic. The notion of play also relates to interpretations, in that when we are fully immersed and engaged in our interpretations, we are taken outside of ourselves, and we are led to where the topic is guiding us (Moules, McCaffrey, et al., 2015).

Moules, McCaffrey, et al. (2015) described the evolution of existing understanding into a meaningful exchange with another as being represented by the image of the hermeneutic circle. To establish understanding was to move within the circle, back and forth between the parts and the whole, and to recognize that the circle, or the whole, had the potential to expand as our understanding widened (Moules, McCaffrey, et al., 2015). Gadamer viewed the hermeneutic circle as a structure of ontological significance, through which we understand; it is important for the researcher to always keep his or her gazed fixed upon the topic regardless of distractions that may be present as he or she generates interpretations such as prejudices, projections, and initial meanings (Gadamer, 1989). Understanding is constantly thrown into question through exposure to new experiences; establishing understanding and allowing one's self to be guided by the topic is not something that is consciously decided, but is rather a constant process that happened as a part of human life (Gadamer, 1989).

An alternate visualization of the hermeneutic circle is that of a spiral, representing the widening of the whole. This suggests that our growing understanding of a topic leads to new associations and ways of understanding, the same way that a spiral may widen and grow infinitely (Moules, McCaffrey, et al., 2015). This representation also further lends to the suggestion that hermeneutics does not seek one truth, but rather to continuously further understanding, the same way that the spiral does not have a finite end (Moules, McCaffrey, et al., 2015). In discussing the relationship between text and understanding, Gadamer also was able to provide a representation of the hermeneutic circle. When looking at a line of text, we may analyze at the level of the individual words that make up a sentence. On their own, these words may have one meaning, however, when put into the context of their place in a sentence, or of a larger text, they may take on a completely different meaning or significance (Palmer, 2001).

Fusion of horizons is a concept that comes up frequently in Gadamer's hermeneutics, however, it is one that has a shifting definition, dependent upon the context in which it appears (Moules, McCaffrey, et al., 2015). One explanation of fusion of horizons is the melding of the horizons of the past and the horizons of the present. Our horizon of the present, which includes our beliefs, values, assumptions, and understanding, is always influenced by our horizons of the past, which is made up of our history, previous experiences, and understandings. Furthermore, our understanding of our horizon of the past will always be influenced by our horizon of the present, and the current understanding that is built around that (Moules, McCaffrey, et al., 2015). The joining of the two horizons is how new understandings are achieved, however, the fusion that occurs is always in flux and never comes to conclusion. The point of fusion of horizons, in which a new understanding is decided, is never seen as a fixed and unmoving answer, because the horizons are constantly shifting and leading to new understandings (Moules, McCaffrey, et

al., 2015; Palmer, 2001). Gadamer believed in the ability to find common ground and did not see the viewpoints of others as a threat, rather, it was a way to enhance one's own horizon (Palmer, 2001). We acquire new knowledge through genuine conversations and being able to acknowledge the viewpoints of others (Palmer, 2001).

Another conceptualization of the fusion of horizons that Gadamer acknowledged was that of text. Written works capture a moment in time and the associated historical context in which the author transposed their thoughts and understandings into text, which represents one horizon. The other horizon in this case becomes the understanding of the reader and the meaning that they bring as they fully engage in the text (Moules, McCaffrey, et al., 2015). Reading a text in the present day could provide the reader with an entirely different perspective than if someone read that same text hundreds of years ago. The words are the same, yet the meaning may be completely different based upon the history the reader brings with them, or the context in which they currently exist (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). While there is not one ultimate truth to be found within the text, the reader approaches from their horizon of the present, and as their horizon merges with that of the text, a new understanding arises (Moules, McCaffrey, et al., 2015). Finally, Gadamer applied the fusion of horizons to conversations, in which each participant in a conversation represents a horizon (Moules, McCaffrey, et al., 2015). As one engages in conversation, and recognizes the viewpoint of the other, the understanding that they are bringing with them may be changed because of the interaction, representing the fusion of horizons (Moules, McCaffrey, et al., 2015).

## Address of the Topic

Moules, Field, et al. (2014) described a moment in which a topic of interest and relevance directs the attention of the researcher and demands that an answer is sought. It was stated that

"no problem just falls from heaven. Something awakens our interest – that is really what comes first" (Palmer, 2001, p. 50). In this moment of address, an individual becomes acutely aware of something, and a desire to find the answer is cultivated. Gadamer believed that there were things that said "something to someone," leaving the individual affected, and reflecting over and over regarding what was said to them (Palmer, 2001). Although it is difficult to identify a finite starting or ending point with hermeneutic research, the moment of address is often considered the beginning of the inquiry, and the moment when the researcher stops and listens to what the topic has to tell them (Moules, Field, et al., 2014). The address disrupts notions and ideas that were previously taken for granted and forces us to question them or look at them in a new way. Moules, Field, et al. stated that the moment of address often cannot be appreciated until something happens that rattles us and forces us to stop and take notice, using the example of catching a bus. When one is running to catch a bus, you do not consider the experience of running for the bus until you have missed it.

I have told the story in my first chapter, of an instance during my early days of being an NM where my staff tested me when they could have helped me, leaving me to feel humiliated and defeated. At this point, I was going through the motions of my NM role, but frequently found myself questioning whether I had made the right choice in leaving the bedside. I loved frontline nursing, and I was good at it; I had steadily advanced through informal leadership roles in direct clinical practice and it seemed that the natural next step in my career trajectory was into an NM role. In my NM role, I felt awkward, uncertain, and worst of all, I knew that my staff could tell this as well. That story always comes to mind when people ask me what it was like to transition into my current role, and when they ask whether it was difficult.

Another reaction that I have received to this recollection is an inquiry as to whether this was my moment of address. In a sense, this moment perfectly illustrates my "missing the bus" and struggling to understand my new role. While it was a poignant experience for me, upon reflection I realize that this instance alone was not my moment of address; rather, this came when I was speaking with another new NM. She acknowledged many of the same struggles, doubts, and moments of utter uncertainty that had been plaguing me. I was shocked to know that I was normal. I had been certain that I was the only NM that did not get it right away and did not hit the ground running. It was in this moment of realization that my topic reached out and grabbed me, and the point from which I knew I had to know more. What came with this moment of address for me was the feeling of responsibility and needing to broaden my understanding so that I could share it with others. Why was it that I was so shocked to learn I was not alone? Certainly, we look up to leaders that inspire us, and I believe that we admire them because they are strong, successful, and wise. We do not see the struggle and the work of becoming a leader that others find admirable, because these leaders have adapted and overcome the challenges that were encountered in role transition.

## Study Design

### Participants

The population being studied is registered nurses (RNs) who have undergone the experience of role transition when moving into NM roles. For the purposes of this study, as well as to ensure that I was able to obtain data that was meaningful and substantive and to ensure that I was connecting with my intended population, it was necessary to further narrow this population. The inclusion criteria for my study participants were the following: RN in an entry level NM role, employed as an NM within AHS in the Calgary zone, in the role for a duration

between three months and two years, and responsible for directly supervising frontline staff. The only exclusion criteria for this study was more than two years of previous management experience. I wanted to focus on NMs in entry level roles and that did not have previous management experience to ensure that I captured the experience of those who had just undergone the role transition from frontline nursing to management. I believe that if an individual had previous management experience or had advanced past an entry level NM role, they may not remember the initial role transition as clearly.

Deciding to include only NMs employed by AHS within the Calgary zone was a choice based on accessibility and pragmatism. As an NM who is currently employed by AHS within the Calgary zone, I had access to my population of interest based on my existing professional networks, whereas it may have been more difficult to identify and garner interest in participating in this study had I chosen to look outside of the Calgary zone or outside of AHS for NMs. This was also the context of my personal experience with role transition, which has been integral to inspiring my research. Given the scope of this project, and for ease of travelling to participants to conduct interviews, it was practical to stay within the Calgary zone. Three months was selected as a minimum of time in the role to ensure that participants had time to acclimate to their new roles and to situate themselves within the experience. Doria (2015) and Weinstock (2011) noted that a duration of 100 days, which is the equivalent of approximately three months, provided NMs with the opportunity to be settled into their role. The literature did not posit an amount of time in which the role transition would be completed, however, Weinstock noted that it could take a full year before leaders felt comfortable in their roles. I chose two years as the upper limit for inclusion in my study because I wanted the opportunity to explore the perspective of NMs that were settled in their roles, yet could still recall the experience of role transition.

**Recruitment**

Participants for this study were recruited through purposive and snowball sampling. These recruitment methods were chosen because I was interested in a specific group of individuals that had undergone an equally specific experience. As such, other, more random, methods of sampling would not have provided a population that had the characteristics that I was looking for. Given that I am currently in an NM role with AHS, I used my professional networks, both formally and informally. Many colleagues were aware of my research interests through engaging in conversation with me and expressed interest in participating. I also suggested that if anyone knew of any NMs that met my inclusion criteria and would be interested in participating that my contact information be passed along to those individuals. Operational approval was obtained to recruit participants in this manner. Intermediaries, who were also AHS managers, reached out to NMs via email that had expressed interest in participating, and provided my contact information. NMs that contacted me, and that met the inclusion/exclusion criteria were included as participants in the study.

Recruitment took place over a two-month period following the receipt of ethics approval from the Conjoint Health Research Ethics Board (CHREB) and operational approval from AHS; a total of five participants were recruited. According to Moules, McCaffrey, et al. (2015), the sample size that is required in qualitative research is that which provides a rich, layered understanding of the topic. The sample size must also be pragmatic for the scope of the research project, and correlate with the number of participants a researcher can reasonably recruit to volunteer (Moules, McCaffrey, et al., 2015). Speaking with five NMs provided me with a rich supply of data that allowed me to establish a deep understanding of the experience of role transition. In conducting my literature review, I was not able to find a study that addressed the

topic of the experience of transitioning from a frontline nursing to an NM role in the highly qualitative and interpretive way that I intended. Furthermore, I was not able to identify any studies that used a hermeneutic approach. As such, it is difficult for me to base my sample size on previous studies, however, given the scope of this research project, and the pool of NMs within my professional network, five participants was reasonable and provided me with meaningful data.

**Study Participants**

Five NMs participated in this study and were recruited using the aforementioned recruitment strategies. All participants meant the inclusion and exclusion criteria that was previously described. In order to maintain anonymity, participants were assigned a pseudonym. My participants were: Sarah, an NM in acute care, with one year of experience in the role; Lisa, an NM in acute care, with 11 months of experience in the role; Alex, an NM in acute care with five months of experience in the role; Sue, an NM in community nursing with one year of experience in the role; and Amy, an NM in community nursing with a year and half of experience in the role.

**Data Collection**

Although Gadamer challenged the belief that the scientific method was the only credible way to establish knowledge, this does not mean the conduct of hermeneutic research is taken up in an unstructured or random way (Moules, McCaffrey, et al., 2015). The way that a researcher approaches being methodical in the conduct of hermeneutics is through consideration of how he or she is engaging with their subject matter. The subject that is to be explored should have significance and contribute to a greater good. The researcher must be thoughtful in all aspects of how he or she approaches the question that he or she is seeking to answer; participants are

selected who have the potential to contribute to the furthering of understanding of the topic, and the researcher must put great effort into being fully engaged in the conversation. The researcher must be receptive, open, and aware of their prejudices (Moules, McCaffrey, et al., 2015). Conducting hermeneutic research is dependent on tact, and a sense of knowing when to listen, when to dig deeper, and when to be with the participant in silence (Moules, McCaffrey, et al., 2015). This tact and sense of knowing how to proceed is acquired through experience in entering into dialogues with others and learning how to arrive at new understandings through participating in these interactions (Moules, McCaffrey, et al., 2015).

Prior to beginning the process of conducting interviews, I spent time reflecting on my personal context and experience as an NM. I identified what my experience was like, and from that reflection, identified what my prejudices were towards the experience. I recognized that while there were certain aspects of the experience of role transition that I found extremely challenging, I could not assume that this would be the case for everyone with whom I spoke. I also acknowledged that while I believe to have come through the experience feeling successful, I also could not assume that every NM that I spoke with would have reached the same conclusion. I could acknowledge the understanding that I had around my own experience but had to be very intentional in remaining open to the fact that there were likely alternative understandings.

To understand the experience of role transition for NMs that have moved from frontline nursing into their first NM role, data was collected through conducting 45 to 90-minute interviews with participants. Moules, McCaffrey, et al. (2015) stated that the practice of hermeneutics is driven by the phenomenon. The researcher must choose the approach that will best allow them to deepen their understanding of the subject matter. Hermeneutics is a practice that is deeply connected with language and dialogue, as is the way that we as humans learn to

understand the world with which we are constantly interacting (Moules, McCaffrey, et al., 2015). For this reason, interviewing was a way that made sense in deepening my understanding of the experience of role transition. The interviews were semi-structured in nature and invited participants to engage in a conversation about what their personal experience of role transition was like. I used a question guide to ensure that I stayed organized and did not forget about aspects of the topic that I wanted to discuss (for full question guide, see Appendix). However, I did not follow the guide in the exact same way for each participant; the questions that were asked and the way the conversation flowed varied with each interview. I paid great attention to being fully engaged in the conversation, and truly listening to what the other person was saying to me. The interview was entered into with a specific purpose and attentiveness towards keeping the conversation moving in a direction that would lend to furthering understanding.

I started each interview by asking the participant to tell me about their nursing career journey, and how they came to find themselves in the NM role. From there, I engaged in a conversation with the participant about particular aspects of their experience that were particularly challenging, surprising, or triumphant. The interviews were conducted in private spaces within the participants' workplaces at a time that was convenient for them. All interviews were recorded on an audio recording device and then transcribed. Upon completion of an interview, I listened to the audio recording of the conversation to seek out things that were striking, or that created new understandings, or questions. I wrote down the thoughts, reflections, questions, and feelings that overcame me as I engaged with my data. I made note of these aspects of the interview and would allow them to guide how I conducted the following interview, or the types of questions and clarifications that I sought from the following interviews.

**Data Analysis**

A significant difference in comparing hermeneutics to others research methods is the process of data analysis. The approach to this task does not seek to reduce the data that are collected to a single theory or organize it into reoccurring themes or categories. Rather, the process of data analysis in hermeneutics is a divergent process in which the researcher focuses on points in the data that further their understanding of the subject matter and widen their understanding (Moules, McCaffrey, et al., 2015). The process of analyzing data requires that the researcher interpret the data that are in front of them. Moules, McCaffrey, et al. (2015) described the process of data analysis as moving through the "landscape of the topic" (p. 118) in such a way that each participant may reshape the opinion of the researcher as they reinterpret and eventually develop an articulation of the data that may be written up. As the researcher engages with the data, they search for words, ideas, or moments that command their attention, in much the same way that the address of the topic did at the beginning of their embarking on the topic (Moules, McCaffrey, et al., 2015). The points that draw the researcher's attention must then be re-analyzed, deconstructed, and discussed among the research team to determine the meaning and understanding that is being conveyed (Moules, McCaffrey, et al., 2015).

The process of data analysis in this study began at the end of each participant interview when I listened back to my interview and made note of any points that were particularly compelling, or that spoke to me. When listening back to the interviews, there were certain phrases or thoughts expressed by the participant that I repeated over and over to myself. These were ideas that I knew required further inquiry and interpretation. I made note of these things, reflected on them, and allowed them to enter my future conversations. A similar process was used while I transcribed the interviews, and I made note of any points that seemed meaningful or

significant as I completed my transcription. Following a period of reflecting upon my interviews, I entered into a dialogue with members of my thesis committee, and we discussed the meanings that were found within my data, the new understandings that were revealed, and the connections and insights that could be made.

Following these conversations, I went back to my data, and again analyzed it using the hermeneutic circle as a conceptual guideline; I engaged with the specific parts, expressions, words, and moments that presented themselves through the conversations that were had, and then stepped back and looked at the whole of my subject matter. I used this process to develop my understandings, and also used the concept of the fusion of horizons. I saw the fusion occurring in terms of the joining of myself with another in conversation and being open to acknowledging the viewpoint of another. The fusion of horizons was also present in terms of marrying my previous understandings with the new ones that had emerged through conducting the interviews. The final step in developing interpretations was revisiting my topic and the learnings that had emerged through the interview process in light of the literature, and considering connections that could be made with that what is already known about the topic. I also considered the topic in terms of interpretive paths that my data led me down, such as theories or other literary works that became relevant in light of the conversations that occurred with participants.

## Trustworthiness and Validity

Trustworthiness describes the researcher's ability to be transparent in their research methods, allowing for the reader to follow the steps that were taken in the research and data analysis process (Sandelowski, 1993). As such, research methods for this study have been clearly documented, and were followed as stated. Additionally, hermeneutic research that is attentive to the method creates a sense of trustworthiness that what the findings are saying is true

(Moules, McCaffrey, et al., 2014). Validity refers to the extent to which one's findings are well-founded, meaningful, and accepted as being true (Moules, McCaffrey, et al., 2014). Being that the aim of hermeneutic research is for understanding, and not explanation, understandings that are generated from this research must be, "strong, powerful, well-rounded, cogent, convincing, robust, healthy, and telling (Moules, McCaffrey, et al., 2014, p. 172). The findings that are generated through interpretive analysis in hermeneutics must resonate with the reader as having truth and being meaningful. Validity was achieved in the data analysis process through not only paying attention to the particular of what the data was saying, but through engaging in conversation with my thesis committee to ensure that I was presenting my interpretations in a way that was clear, comprehensive, and rang true for the reader. Aspects of my analysis that did not resonate with my committee members were discussed and revisited to ensure coherence and applicability of my findings.

## Ethical Considerations

Ethics approval was received prior to commencement of this study from the CHREB (REB18-0646), and consideration was given to the principles of beneficence, respect for human dignity, autonomy, and justice (Polit & Beck, 2017). There is a minimal risk of harm to participants in this study, given that there was no intervention applied, and participants were invited to participate in a conversation about their experience. There was a possibility that participants could find the conversations or recollections of their past experiences upsetting, therefore I checked in with participants throughout the conversation and let them know they could stop if they were uncomfortable at any time. In the interest of respect for human dignity and autonomy, potential participants were made fully aware of the aims of the study and were only recruited if they contacted me and provided consent. Individuals freely chose to participate

in the study and retained the right to withdraw consent and participation at any point prior to the commencement of data analysis. Justice was addressed in this study by maintaining the participants' privacy and anonymity. Potential participants were contacted by a third party, however, that individual was not made aware of the participants' response or lack thereof. There is the potential that I may interact with participants in a professional capacity as we work for the same health organization, however, the participants' involvement will not be discussed outside of this research. Participants were assigned a pseudonym to protect their identities, however, it is difficult to guarantee anonymity given the relatively narrow scope of my inclusion and exclusion criteria.

## Concluding Thoughts

Through the research process, I was able to take a musing that seemed important to me, and systematically think through the process necessary to answer a question that needed to be answered. A hermeneutic approach allowed me to work through this question in a way that was methodical, thoughtful, and made space for expanded understandings of the experience of role transition. Prior to beginning the journey to establish this understanding, I had to give careful consideration to the philosophy that formed the foundation of hermeneutics, and to ensure that I had a thorough understanding of the important aspects of the method. Through paying attention to language, aletheia, and genuine conversation, I was able to conduct five interviews that led to meaningful, candid dialogues about the experiences not only of my participants, but of myself as well. Entering into the interpretive process required reading, re-reading, listening to what was said, attending to what was not said, and allowing myself to continue to ask questions to further my understanding. The understandings established by way of this research are discussed in the following chapters.

## Chapter 4: Shifting Nursing Practice Away from the Bedside

When designing my study, one of the inclusion criteria for participants that I considered essential was that the NMs that I interviewed were RNs. This distinction was important because it is possible that those who manage nurses in the healthcare setting may come from varied professional backgrounds such as physiotherapy, HR, or administration. While the NM title does not exclusively belong to RNs that manage other nurses, this is the specific role transition experience that I wanted to better understand. I spent time considering what it means to be a nurse because while I am exploring the experience of role transition from frontline nursing into management, the NMs that I spoke with that had undergone this professional shift were all RNs and had begun their careers in a distinctly nursing capacity. Not only were the NMs that I spoke with RNs, but they were also responsible for the direct supervision and management of nursing staff, therefore, their ties to the profession were obvious and important.

While my participants may no longer fit the typical presentation of what one may imagine when one thinks of a nurse, they would likely all identify themselves in this way. I would say the same about myself. At times it strikes me, now that I have been away from the frontlines of nursing and have not provided direct patient care in a number of years, that I would still identify myself as a nurse before a manager. When I meet a new person who, in making polite small talk, asks about what I do, my instinct is to say nurse, not NM, because being a nurse is something that people understand and can relate to, and is easier than going down the rabbit hole of explaining the NM role. In much the same way that I consider acute care my home, I continue to identify with my nursing role professionally. It seems that part of transitioning into the NM role is leaving behind a part of one's nursing identity; it is a case of becoming the other. As a frontline nurse, NMs seem far removed from nursing practice, seem to play for a different

team, and belong to a different world. Through speaking with my participants, all of whom were at different points in their role transition, I was able to gain insight into how they negotiated this change in professional identity, either consciously or unconsciously.

## Perceptions of a Nurse

Merriam-Webster (n.d.) defines a *nurse* as "one that looks after, fosters, or advises; a person who cares for the sick or infirm." I suspect that if you were to ask a person what image comes to mind when they picture a nurse they would likely describe a doting caregiver, attending to the medical needs of a patient, likely within the context of a hospital setting. Hoeve, Jansen, and Roodbol (2013) discussed public perception of the nursing profession, noting images of nurses as angels of mercy, doctor's handmaidens, and caring, skilled professionals; nurses are highly respected by the public, yet may be faced with limited career opportunities. An important point of the discussion by Hoeve et al. was that the public image of nursing is largely based upon misconceptions and stereotypes, but nonetheless, these images and associations feed nurses' self-perceptions. When I examine my personal perception, I would say that the acute care setting and bedside have always been inextricably tied to my vision of the nursing profession, as well as to my nursing identity. Although my career path has shown me that the roles and opportunities for nursing extend far beyond the bedside and are not limited to the hospital, being an RN will likely always be tied in my mind to providing direct patient care on a busy ward.

Considering what it means to be a nurse also meant considering the history of the nursing profession, which has origins dating back to the mid-19$^{th}$ century (D'Antonio & Buhler-Wilkerson, 2019). D'Antonio and Buhler-Wilkerson (2019) noted that professional nursing began with Florence Nightingale, arguably one of the profession's most well-known and influential members. Florence Nightingale is considered the first person to articulate a

professional nursing role while caring for the sick in the 1800s, with a particular focus on preventing the spread of infection and disease (Strickler, 2017). Affectionately called "the lady with the lamp" for her willingness to round on her patients late at night by candlelight long after she had relieved her colleagues of their duties for the evening, Nightingale went on to greatly influence the nursing profession, establishing standards for nursing practice and education (Strickler, 2017). Moving from the time of Nightingale towards modern day, nursing practice has evolved as the years have passed; hospitals became a prominent setting where nurses practice, professional associations, practice standards, and regulating bodies were established, and nursing education shifted from being hospital based to requiring a college or university education (D'Antonio & Buhler-Wilkerson, 2019). Nurses have been seen, throughout history, to play a pivotal role in garnering positive patient outcomes through expert care, knowledge, and their care of the sick and unwell (D'Antonio & Buhler-Wilkerson, 2019; Strickler, 2017).

When I think about the image of a nurse that I connect with, or the image of the nurse that the general public associates to the role, what stands out to me is that my five participants, who were all RNs, did not look like this version of a nurse. Scott and Miles (2013) reported that the general public often do not see a connection between the NM role and the nursing profession. The people that were in front of me and engaged in conversations about their experience of role transition did not look like doting caregivers dressed in scrubs and supportive shoes designed to keep them on their feet for long hours at the bedside. They did not come with stethoscopes draped around their necks, on the ready to assess a patient, provide compassionate care, or find themselves enthralled in a moment of life or death clinical decision making. Rather, I was presented with people that came to my office and sat across from me at my desk dressed in business casual attire, without a piece of medical equipment attached to their person, who looked

like they could have just as easily stepped out of a cubicle in an office. I predict that if a person who did not know these individuals had to guess their profession or industry, that the last thing to be guessed would be an RN in healthcare. The majority of the interviews took place during or at the end of the participants' workday, and yet not one of the participants had provided patient care, completed an assessment, or done any of the number of tasks that are typically associated with the nursing role that day, and yet, they all still were RNs within the NM role.

## Becoming the Other

Stepping into the NM role is a little bit like switching teams; it is a move away from the frontlines, from the clear path of the professional nursing role that was carved by Florence Nightingale, towards the relative unknown that shrouds formal leadership.

> *You don't really see that other side of management when you're kind of progressing through your career, you don't realize how much of the other stuff there is, rather than just what I thought was being a leader.*

Sue, who now managed in an area where she had worked for years, thoughtfully spoke these words as she described her move from frontline nursing into management. She was someone that had pictured her career steering in this direction, but had not anticipated the dimensions of the NM role that were unseen to her prior to working in this capacity. More than just learning new skills, this role transition is one that required a shift in identity which may cause people to underestimate the challenges that come with this change. Alex, only months into managing an acute inpatient nursing unit, thought about her move into an NM role, and described moments of feeling like she had no idea what she was doing, despite an implicit expectation that she was a leader capable of making important decisions. With an air of lightness, she described her morning drive to work her first few months as an NM, white knuckles gripping the steering

wheel, terrified to encounter her day. She had not felt this way since she was a new graduate, stepping out as a nurse on her own for the first time.

> *We're supposed to be calling the shots. So that's what I had huge anxiety over. I didn't even really know the expectations of what I had to figure out. It took me a long time just to figure out what I had to figure out.*

Becoming the other requires negotiation and acknowledgement of one's current position. While NMs are often selected and promoted based upon clinical expertise and proficiency (Doria, 2015), these past skills do not always have a place within a management role; new NMs must acknowledge that while their nursing identity has equipped them with clinical knowledge and ability, these things do not necessarily translate to their new role, and could distract them from focusing on the tasks that are now required and expected of them.

Sue, being very familiar with the frontline duties of the area that she was managing, recalled the intentional way that she tried to provide support to her team at times when they were short staffed. She was torn between her nursing identity and skill, which would have enabled her to act as a frontline staff member, and the need to work within her NM duties and fulfill those responsibilities.

> *I would carry pagers if I had to for our units, but it was then also knowing your limitations, my role at the time really isn't to do discharges, and I don't mind meeting with people and doing family meetings and that . . . but sometimes I struggled with that as well because I also have stuff that I have to get done. So how do I get all that done?*

Lisa, who was managing an inpatient nursing unit where she had no clinical experience, experienced a similar pull to help her new team from within her role as an NM, however, recognized that her ability to do so was limited because she was managing an area she had not

worked as frontline. Whereas NMs that have knowledge of the area where they work must make the conscious decision to draw that boundary in roles, Lisa found that this was a delineation that was made clear based on her lack of clinical experience. It was not as easy for Lisa to slip back into her nursing identity or for her new team to see her in that way because this was not somewhere that she had been a frontline nurse before. She said, "because I'm not a nurse in the area that I'm managing, I can't really help you, I don't have any clinical knowledge."

Not only must new NMs find a way to balance their identity as a nurse with the demands of their new roles, they must also endeavor to determine what type of leader they want to be. I consider this a movement towards embracing their new professional identity, and a clear acknowledgment that they are seeing themselves not as a frontline nurse, but as the other, as the leader, the boss, and the NM ideal that they envision for themselves. Sue had a clear vision for the type of NM that she saw herself being and referred to it often throughout our conversation.

> *I guess it comes down to the type of manager you are and feel you want to be, but you definitely feel like you're on call 24-7. And I always wanted to be the type that would be available if they had any problem . . . I was consumed by work a lot of the time. Which was okay, I was wanting to be the type of manager that was available and accessible.*

Alex recalled the positive example that was set by one of her previous leaders and described how it influenced her as an NM:

> *My old manager was amazing, and she always did her best to support the staff, like bent over backward to help people . . . So, if she told you something negative or gave you strong feedback, you took it seriously because you felt like she was on your side. I've learnt from that, and I really like that style*.

Amy had a different experience, in which a negative example helped her to identify what she did not want to become, and said, “there’s some that have encouraged me to be a good manager by their lack of good management. There’s a few people where I’ve said I will never be a manager like that.” Good or bad, the way that new NMs envision the leader that they would like to be inspires the new professional identity that they move towards, and the other that they will become.

## The Desk

In speaking with my participants and discussing the dimensions of their current roles as NMs, something that struck me, and something that I heard many times, was mention of their desks. Sometimes it was mentioned in the context of being where they worked, and the object that they sat behind, completing the tasks that were associated with their role. Interestingly, I can recall in my time working at the bedside, speaking about “the desk,” and even now as an NM, hearing my nursing staff mention the desk. However, the desk in a frontline nursing context is not the desk where an NM spends his or her day; it is the main nursing desk, the main hub of activity on the nursing floor, where all of the comings and goings on an inpatient unit intersect. At this desk the charge nurse is the captain, sitting in the center of all the activity on the unit, as if sitting at the helm of a great ship. Nursing staff, physicians, patients, families, and other members of the multi-disciplinary team approach to question, direct, discuss, and collaborate. There is no doubt that this is a busy place, and the people that sit at it, and approach it, are busy and helping drive forward the operations of the delicate ecosystem that is the nursing unit. The main nursing desk can provide a physical boundary between nurses and patients, and can be used to describe how hard a nurse is working. A nurse that is perceived as spending too much time at the nursing desk may be doing so at the cost of care and attention to his or her

patients. Although the desk is not a new term or not a new piece of furniture, the desk that one works behind as an NM is not the same as *the* desk. It is not revered, and it does not have the same, almost palpable, hum of energy that an inpatient unit's main nursing desk has.

Instead, the desk that I heard participants speak about is something that the NM needs in order to have a place to do their work, check their emails, recruit new staff, and have crucial conversations. Alex, who manages an inpatient medical nursing unit, saw her desk as something that divided her from her staff, and changed the way they looked at the work that she was doing. She said, "so staff, they see you sitting at your desk, right? So, your work is kind of invisible." Alex believed that frontline nursing staff see the work of being a nurse as the tangible tasks that come with their role, and in this statement, she expressed feeling that her staff did not see the endless tasks that she was responsible for, tasks that allowed the nursing unit that she managed to continue to function. Sue reflected on the many tasks that she was responsible for as an NM, many of which would not be visible or obvious to staff, but were an integral part of her role, *"*there's still lots to learn and lots to grow with. With the management position, you're dealing with workplace health and safety, and HR, and just different personalities, and you have to figure out how to work with people." As Sue described the learning curve that she had to work through in her NM role, something that stood out was the difference in the work; none of the things that she was now doing were reminiscent of the work that is associated with frontline nursing.

Furthermore, the setting required to do these tasks was entirely different; these were all things that were done in an office, sitting at a desk. Success in these tasks could not be found on the nursing floor or at a patient's bedside. The NM's desk is no less a place of work than is the main nursing desk for frontline staff, however, frontline staff may not look at it in the same way. Sue considered the possibility that a great deal of her work as an NM is hidden by the ways in

which her work is done. The fact that so much of the NM's work is related to communication and problem solving that staff may not be able to see may also make it difficult for frontline staff to appreciate the workload and difficulty that is associated with the role.

> *I think because a lot of things are done via email and telephone calls, they don't always see piles of paper. Maybe the old days, when a lot of stuff was paper and you could see when someone had a pile of stuff on their desk, now we just have a pile of emails that nobody else sees.*

Maintaining the operations of a nursing area requires a great deal of time and energy put towards tasks that leave no physical evidence for frontline staff to observe. When an NM spends hours trying to manipulate the numbers in a spreadsheet so that the operational budget balances out or meets its current, ever-shrinking target; when an NM reviews, screens, and shortlists hundreds of potential candidates for positions in the clinical area; when an NM answers handfuls of emails that rolled in since the last time they were in front of their computer, it might not look like much to a frontline staff member that observes that NM. It might look more like a person who gets to take a load off behind a desk, illuminated by the soft glow of a computer screen. Interestingly, the same may be true of how patients and families perceive the main nursing desk, and their interpretation of seeing health care professionals sitting here, working in front of a computer. The work of the main nursing desk is vital, and yet, it may not appear to hold the same value as tasks that require being with patients and their families, providing direct care, and engaging in therapeutic interactions.

**The Invisible Work of the NM**

I question whether it is that frontline staff do not see NMs as doing important tasks, hence leading to the feeling of invisible work, or if it is the NM that does not equate the same

merit to his or her current tasks as they did to those that they completed when they worked in a frontline capacity. NMs that still connect to their nursing identity remember what it was like to touch patients, provide support, and provide life-changing care. The work of the NM typically does not provide the impact or feeling that the work of the frontline nurse does, and yet, their work is crucial in supporting the health system and making it possible for frontline staff to provide care. This supposition pulled me back to a journal entry that I completed in the early phases of my research. In much the same way that I do not always connect with my NM identity when speaking about my work, this same uncertainty, or assignment of weight and value was seen in my personal reflection. I compared my topic and my work to the research of my nursing colleagues and could not help but see how my shifting professional identity permeated these thoughts.

> *Some of the topics that are addressed are so moving, so important, so captivating…They have explored topics that are life and death, that capture the heart of nursing, of caring, and sometimes I look at my research topic and think – "meh." This is a topic that isn't sexy, or exhilarating, part of me feels that a lot of nurses might look at it and roll their eyes . . . there are no life or death moments, you don't save lives, you don't get looked at as a hero, or an angel. Sometimes you are just that guy, the bad guy, the face of what is frustrating your team most at that moment.*

Sue was able to recall her perception of the NM role from when she was frontline and was able to appreciate a significant change in this view after having assumed the role herself. I asked her if she understood what the role would be like prior to her entering her NM position, and she said:

> *I thought I did, yeah. I thought it was like, fairly easy. Like you're there to support people. You're there to bring forward changes that happen . . . but when you're in the*

> *role, it's definitely a lot more. We used to say, "why do we need two managers?" But after I was in it, I was like, geez, you could almost use three or four managers sometimes because of some of the issues that come up . . . You are there to support, but you don't realize how many times you're getting pulled in ten different directions.*

With this, Sue validated the sense of invisibility that Alex articulated, of feeling like her staff did not understand the work that she did.

Sue recently returned to her frontline nursing position; she left her NM role in response to challenges in her personal life. Based on her experience as an NM, she stated her belief that it would be invaluable for frontline staff to understand what the role entails, and, "we don't give our managers enough credit for what they have to deal with and situations that they come across, and just all the background work." This revelation that frontline staff do not have a clear grasp on the role came from an individual that was able to articulate an interest and an active pursuit of an NM role; Sue had considered the position, viewed it, and deliberated over what the role would entail and whether she thought she could meet the demands of the job. Even with all of that conscious thought and consideration, Sue still revealed that she did not see all of the work that came with the NM role, supporting the feeling that the work of the NM may be considered invisible by frontline staff. The work of the NM is simultaneously invisible and unrelenting; Alex spoke to the overwhelming volume of work that she encountered, saying, "I was super high strung, trying to get everything done. One of my colleagues, she's like, you know what, you're never going to get it all done, so just do what you can, do your best." This feeling of anxiety with overwhelming things to do is in stark contrast to the easy role that frontline staff may associate with someone who does the majority of their work sitting behind a desk.

Beyond being an instrument that changes how frontline staff view the work that they are doing, an NM's desk was referenced many different ways by participants, for instance, it is something that determines the flow of our day and prescribes what tasks we will be responsible for. I asked Lisa what surprised her about the NM role and she said:

> *If somebody asked you to outline exactly what you do, like what is your job description, I think you have a basic idea and then the rest of it is whatever comes across my desk is what I do that day. And I think I found that a bit surprising, just that there's so many things that land on your desk – there's no real way to prepare for that.*

Rather than being just a piece of furniture, a desk is the determinant of how an NM's day will go, it is the vessel that carries the problems that will cause the NM's day to veer off course, and steer the NM towards an unexpected direction. Or, if the desk is kind and forgiving that day, perhaps one will have the opportunity to adhere to the events that he or she originally had planned. At times, the desk is also the obstacle standing between the NM and his or her staff; it is what makes the NM different from his or her staff, and it is what changes how he or she is viewed by the team. This is in parallel to the physical boundary of the main nursing desk, separating staff from patients and families. As Lisa made this statement, describing the way that her days were at the mercy of whatever came across her desk, it created the image of the desk coming alive. The desk took on a human role, of a fate decider, or a puppeteer, tugging at the strings of the day that you thought that you were going to have, and taking you down whatever path the desk thought you should follow that day. This speaks to the overwhelming feeling of not being able to get it all done, and of being pulled in many different directions.

The work of the NM seems to center around the desk, or at least, this is the way that participants seemed to relate to the work that was expected of them. Not only were there "things

that come across your desk that you have to do and you have to action," but there were additional projects that were expected of NMs that they did "off the side of my desk." This is an expression that I have heard time and time again, speaking to the many tasks that are expected of NMs that go beyond their "regular" tasks or duties. These include things like quality improvement projects, contributions to site wide initiatives, or make-work tasks that were handed down from the leaders above. Alex talked about a project that got dropped on her desk, a body of work that she felt too busy to take on with everything else that she was attempting to navigate, being relatively new to the role. Despite the overwhelming nature of all that she was struggling to balance, she felt that she could not say no. She said:

> *I don't like the feeling of not getting back to someone, but I'm finding it very difficult to juggle this project . . . I've got the best intentions of doing it, but just, I have no time . . . I should have said no . . . I find that when you're sitting in the unit manager's chair, you've got a lot of balls in the air all at once.*

This was not a project that Alex willingly took on, or an opportunity that she chose to jump on, it was dropped onto the mountain of work that already existed on her desk.

I suspect that NMs do not give a great deal of thought to the desks that they are sitting behind every day, and that most have likely never contemplated the power that their desks have over their day or their productivity. But the desk is more than a piece of furniture; the NM desk is symbolic of the role and symbolic of the shift in professional identity. Here, we see that NMs have moved from the bedside, arguably the most easily identifiable symbol of the frontline nursing role, to the desk, and towards their developing identity as a manager and a formal leader. The NM desks hold a similar pull to the bedside, but in an entirely different context. In the same way that vigilant and effective frontline nurses may feel that they cannot leave the bedside when

their patients need them, an NM may feel the same sense of not being able to step away from their desk. I can think of many days where it was well past the time that I had promised myself I would head home, but despite my best intentions, I could not leave. I felt chained to my desk, and like if I left I would only return the next day to see an even higher mountain waiting for me. The word *chain* means "to fasten, bind, or connect with," (Merriam-Webster, n.d.) and perhaps this same feeling of obligation to our desks, that we once felt to the bedside, is an indication of coming into the NM role. Some of the tasks that NMs are responsible for also lend to the feeling of being chained to one's desk, or at the very least, hesitant to step away because surely that will be the moment that the email or phone call that he or she has been waiting for will come through. An NM's desk is typically also the place that people, including frontline staff, other leaders, physicians, and various other members of the multidisciplinary team, know that the NM can be found. This again lends to a feeling of obligation, of being present at one's desk, and available to any person that might approach it.

I have often thought of my desk, and the status of it, as being an outward reflection of how I am doing. On days when my desk is pristine and organized, with everything sitting in its right place, I feel in control, and like I have been able to address and handle any of the priorities that have been sent in my direction. However, that is not always how my desk looks, and in fact, I would say that most often it is in a state of relative disarray. There are stacks of paper reports that need to be reviewed, meeting minutes and agendas for me to file away, with the blank spaces between the piled up work filled with post-its and notes to myself, reminding of tasks that cannot be forgotten, things that I need to remind my staff to be aware of, written with good intentions but have now been rendered impossible to decipher. When I worked as a frontline nurse, I used to hear people that worked in offices talk about the need to clear their desk off, and

at the time, I had no sense of what was meant by this, but now, my goal at the end of every week is to work through the piles of work that I have sitting on my desk. One participant reported a perspective change and adjusting her expectations of herself, "it's never going to be perfect…realizing that you're never going to clear off your desk." This statement communicates the implication that a clean desk denotes an NM that has it all figured out and is doing a good job.

Like Sue noted, it is not always obvious when an NM is overwhelmed and overloaded; sometimes this is because people that pass by cannot see mountains of emails, phone calls, and mental to-do lists, and sometimes, it is because "busy" for an NM looks much different than it does for a frontline staff member. There are no alarming medication pumps, screaming patients, or call bells sounding when the NMs' tasks have lined up throughout the day. They are not seen speed walking from one end of the unit to the other, with their arms full of supplies, looking increasingly disheveled as the shift wears on. Busy, for an NM looks different; it is often quiet and takes place behind the desk that has become their new home base. It is striking to me that the NMs that I spoke with, myself included, have experienced such a drastic shift in their practice environments despite remaining RNs. All of my participants remained in a setting that they have previously practiced in, either acute care or the community, and yet, despite being within the same unit, building, or organizational structure, their practice setting and way of working has changed significantly.

## Professional Identity

The change in practice setting experienced by my participants lead me to consider how this may impact the professional identity of NMs, and how NMs may remain connected to their nursing roles despite finding themselves in such drastically different positions. Weinstock

(2011) noted that with changes in opportunity, particularly those related to career advancement, individuals must change how they perceive themselves, which is applicable to this role transition. In frontline practice, nurses are able to derive satisfaction and contentment in their role through helping patients and providing care. There is a sense of accomplishment that follows a hectic day on the nursing floor, where you were able to manage competing priorities, appreciate positive outcomes, and connect with patients, families, and colleagues through the challenges that come with this type of work. These rewards for a job well done do not come in the same way for NMs despite the fact that they are RNs working in health care. While there is satisfaction associated with completing a task or receiving positive feedback, it is not the same, warm feeling that accompanies being with patients and families in vulnerable moments, and providing care that has the potential to impact health and wellness. Luo et al. (2016) found that NMs had to embrace the fact that their new roles were significantly different from their previous clinical work.

Throughout the process of conducting interviews, the impact of the NM role on professional identity was not something that jumped out at me, and therefore, was not something that I asked my participants about. There was no inquiry as to whether they still felt like a nurse, or whether they felt that there were certain pieces of their professional identity that had been left behind. Despite this, many of the participants discussed aspects of the NM role that they found positive or triumphant, or reasons that they had for stepping into the role in the first place. Amy, who managed a team of nurses in the community, spoke about her motivation for becoming an NM, and through this, I got a sense of her connectedness with the nursing role, "having the opportunity to maybe manage nurses or mentor nurses to become *really* good nurses. Like really solid nurses that you want looking after your family . . . You can tell which nurses care, which

ones don't, right?" Alex expressed a similar sentiment in terms of where she gains enjoyment through her role and how she maintains connection to direct care as an NM.

> *I get satisfaction from trying to think from my nurses' perspective and making their jobs easier. So that they can care for the patients better. I hope that I keep that perspective and try to see it from their perspective because really they're the ones that are out there doing everything with the patients . . . I think that if they feel supported and happy, they are more likely to put in the extra mile.*

For Alex, appreciating the frontline perspective enabled her to support her staff in such a way that they might be more effective in the quality of care and service that they provided.

Mackoff and Triolo (2008) found that it was important for leaders to see their work as having larger purpose, and to see the success of their staff as a demonstration of leadership strength. This provided a source of job satisfaction in helping to build capacity in the future generation of nurses, and enabled leaders to keep their line of sight towards the frontlines of nursing. This line of thinking, combined with some of the motivating and triumphant moments that my participants shared with me, illustrated how in spite of how our roles have changed, we maintain connection with our nursing identity. While it is no longer the NM's job to provide the hands-on nursing care and expertise that previously defined his or her career, they maintain connection as an RN through ensuring that staff are supported in the ways that they need, and that the frontline perspective in woven through the decisions that the NM makes. Despite how different the NM role is from frontline nursing, there are still ways to touch patients through the support that is provided to staff, and to maintain a connection with the aspects of the profession that drew so many nurses to it in the first place.

## Concluding Thoughts

From speaking with my participants, as well as considering my own experience in role transition, it is striking how vastly different our practice settings have become, despite still working within the same health system, same organization, and with the same professional designation. The change in role that we each undertook moved us from working bedside, or in some cases patient-side, to working desk-side. Rather than working amidst a dynamic, fast-paced nursing environment, NMs are seated behind a desk, at times feeling far removed from the nursing floor, from direct patient care and interaction, and from our staff. Often, the desks that we are stuck behind seem to hold such great power over us, in determining our day, in showing others how we are doing, and in keeping us chained to them, bound to stay glued to our chairs to work through whatever tasks our desks will serve up that day. Although the meaning that is tied to the NMs' desk is vastly different than the "the desk" that most NMs were once accustomed to, it remains an important hub in being able to positively influence the nurses that they supervise and support, and as an extension of their leadership, positively impact the care that patients receive. The notion of becoming the other, and shifting professional identity has distinct ties to hermeneutics. The notion of aletheia is present as one moves through the transition into an NM; parts of the distinctly nursing identity are let go, and concealed, as one assumes their place as an NM, unconcealing a once foreign role, and taking in all that comes with this position. A fusion of horizons occurs as a new NM blends their past experiences and identity with the new role and context that they have encountered, with this history playing a significant role in the NM that they are to become.

## Chapter 5: Relationships in Transition, Breaking Down and Rebuilding

Fry et al. (2013) and Henderson (2001) stated that caring is a defining characteristic of the nursing profession. Caring is defined as "the mental, emotional and physical effort involved in looking after, responding to and supporting others" (Fry et al., 2013, p. 38). While compassionate care is a cornerstone in establishing therapeutic relationships and helps to establish engagement and satisfaction within the nursing role, it is also important for nurses to regulate their emotions and responses as a protective measure to avoid burnout and care fatigue (Banks van Zyl & Noonan, 2018; Henderson, 2001). The inextricable notions of caring and compassion in relation to nursing demonstrate that it is a highly human profession, with great emphasis placed upon the art of nursing, and the relationships that are forged with patients and colleagues through the provision of care. To show caring and compassion is to be human, and likewise, to be caring is also to be a nurse. In the previous chapter, I gave consideration to commonly held notions of a nurse, and through that contemplation was also the image of a nurse as being kind and compassionate, looking after the sick and unwell, and a beneficent caregiver.

### You Are Nobody Until Somebody Hates You

I spoke with Sarah, who now finds herself managing the area where she previously worked as frontline staff, and she shared how it was that she came to find herself in the NM role. The possibility of management was one that had always occurred to her, but she did not anticipate that it would happen when it did. When the position that she now holds was posted, she ignored it, and did not apply, because like she said, the timing just was not right.

> *My kids were little. My kids still are little. I wanted to wait until my daughter was in kindergarten before I transitioned to a full-time job. I also wanted to finish my master's beforehand, and honestly, I thought my career path was more education than leadership.*

The position was not filled, and with no suitable candidate to step into this leadership role, it was posted a second time. At this point, the wheels started turning, albeit slowly. Always thought of as a "quiet leader," the pre-contemplative thoughts crept in, and Sarah started wondering if she could do it, wondering whether this was actually the path that her career could take.

> *I was on the social committee, on the SMART [*unit quality improvement*] committee, I was always able to see the bigger picture. I would be like, no one gets into healthcare to make money, we are spending the public's money and we have to be accountable to that. I was very patient-focused and just really good at sharing my opinion without making people feel bad. I've been called a quiet leader or a gentle leader…I was interested in how to improve our unit and to be able to be in a position to actually make those changes, make those improvements. Make a difference.*

Her colleagues provided the final push that she needed to take the chance and convinced her to apply. Sarah was not confident that anything would happen, was not certain that she would be considered, but thought that she would see what happened. Although her colleagues could see her potential, she acknowledged that she did not stand out in the eyes of her manager.

> *Honestly, my manager didn't know who I was at all. She probably wouldn't even recognize me in the hallway beforehand. I was just one of those people, not a complainer, not in my manager's office, yeah, so just one of those people that's kind of under the radar.*

What happened next was something that Sarah had not planned for; she was the successful candidate and new NM for her nursing unit. Whether or not she was ready, she was now the boss, the leader, and as she so eloquently put it, "the opportunity came before the timing." Sarah could not have anticipated what happened next, nor could she pinpoint the exact moment or

reason that things changed, but she reported a dramatic transformation in her workplace relationships.

She found challenges in communicating her message, setting new boundaries with her former colleagues, and balancing her vision of improving her workplace with the realities of what could reasonably be done based on the current resources and limitations imposed by policy and organizational priorities. The importance of communication in establishing understanding speaks to the gravity of this challenge; a lack of ability for Sarah and her staff to communicate successfully denotes the inability to establish common meanings, goals, and understandings within the workplace (Moules, McCaffrey, et al., 2015; Zimmerman, 2015). Sarah frequently paused as she recounted the challenges that she encountered, carefully measuring her words, and finding the most diplomatic way to articulate the hard truths.

> *I've had a lot of…issues with my staff. And my staff have been really unhappy. And things like "you used to be so pro-unit and I thought you're going to be on our side, and now you're so pro-management." Yeah, well, I have a job to do . . . I've butted heads and been in conversations that haven't been very respectful. I've been told, "I don't trust you, you talk out of both sides of your mouth," and it's that exactly.*

What struck me about her experience was how jarring it must have been to experience such a drastic shift in her relationships in the workplace. She went from being someone that was well-liked by her colleagues, and deeply embedded in the social aspects of the unit. In fact, she was so respected, that she was encouraged to pursue her NM role by the same colleagues that were now fully on the offensive against her. I contrast the treatment that she was subject to against the image of nursing as a caring profession. It seems difficult to believe that amidst a role that is

synonymous with caring, compassion, and kindness, members of this profession can behave in a way that is so contrary to these qualities.

While the type of treatment that this NM experienced throughout her role transition was terrible, in a way, it was not overly surprising. Perhaps this was because I also encountered a level of maltreatment from my new team, and perhaps this is because the literature available about role transition for NMs alludes to these such challenges, warning that it can be difficult to re-negotiate boundaries, and gain acceptance within a new team (Mackoff & Triolo, 2008; Weinstock, 2011). It is not shocking to hear that this type of behavior exists since the literature also says that the NM role can be lonely, and isolating, and outlines that one's social dynamic is subject to shift within the context of a new role (Doria, 2015; Mackoff & Triolo, 2008; Weinstock, 2011). However, despite knowing that facts around this challenging aspect of role transition, what the literature does not detail was how painful these challenges can be. Sarah did not say it outright, but there was a distinct air of sadness, and a feeling of defeat when she referenced these negative encounters. As she told her story, she searched for the right words to tell the tale in a way that was objective and fair, perhaps serving as a shield for the sting that her recollections carried. Sarah went from being heavily engaged in her unit, both in the sense of having good relationships with colleagues, and contributing to the unit's functioning as a well-respected staff member and committee participant, to being pushed to the outskirts of this group. I anticipate that this must have left Sarah feeling blindsided; not only had her existence at work changed suddenly and distinctly, but the negative reaction that she received came from the same people that encouraged her to apply for the role in the first place.

Furthermore, it appears that because we know that the NM role is challenging, and the transition from frontline nursing can be tough, there is an expectation that those in the role

cannot feel the resultant despair, sadness, and doubts because "they knew what they were getting into." This sentiment was mirrored in the words of Alex, who stated, "you know you don't go into a role like this to make friends…you have to be able to be independent and take that risk." It is as if because an NM is in a position of authority and is often tasked with making difficult choices or saying the things that people do not want to hear, that they lose the ability to be affected by these difficulties. As an NM, you feel that you have to be tough because the role demands it, and you have to grow yourself an exceedingly thick skin because you can anticipate that people are not always going to like the things that you do. Sarah remained composed, chose her words carefully, and did not speak to the full impact of the treatment she had endured. I do not believe that this is because she was unaffected by the actions of her team, but rather, because she was maintaining the tough exterior that NMs need to have to be successful and seen as strong within their role. It is human nature to want to be liked and do things that are pleasing to others, but at times, this seems like it is not a reasonable expectation for an NM to have of himself or herself. Being able to remain composed through such adversity is a sign of success as an NM, and the exposure to poor treatment and, at times, outright abuse, is a rite of passage, a sign that you have made it.

Sarah talked about how feedback she has received from her staff has made her feel:

> *The other thing I've heard is that I don't value people, or I don't think of them. So that's been really hard for me . . . I find that to be the worst feedback ever because that's so not my personality, like I never set out to hurt people or anything like that. But I think sometimes they target their comments specifically with the intention of hurting you.*

The expectation that an NM be tough, and able to take any sort of abuse or mistreatment that comes their way is not just a self-expectation that NMs place upon themselves, it is reflected in

the opinions of the frontline staff that they are responsible for leading. Sarah once overheard this statement by one of her staff: "in order to be a manager, you have to be okay with not being liked." Her reaction was simple, but highly poignant: "I'm still a human being too, you know." Sarah communicated the sense that her team had lost sight of this fact, of something that should be obvious. Despite her role as an NM, she still has a beating heart, still breathes oxygen in and out, and still has thoughts, feelings, and a life outside of the workplace, just like every other person in the world. The statement made by that staff member reflected the belief that because of the role that they chose to be in, NMs should not expect respect or kindness from their teams, and have forfeited their right to feel disappointed or upset by this. Sue recalled interactions that she had witnessed between frontline staff and NMs, and thought that an aspect of the NM's humanity was lost in the eyes of his or her staff.

> *I think that sometimes they can forget that you have a life outside of this. From some of the staff [*at my previous workplace*], I can definitely see how that could happen and they could definitely forget that there really is a human there. Even with their last care manager [*NM*] leaving, there was a comment that was made to her, that one person said, "I did my job, I got you out of here."*

Through moving out of the frontline nursing team, it is as if NMs have given up the right to be thought of as human beings and are instead thought of as faceless representations of the management bureaucracy. Whether or not it is their intention, the move into the NM role is a switching of teams, of going from being one of us to being one of them, from being the good guy to being the bad guy.

Sometimes, the way that NMs become less human in the eyes of their staff are less drastic, and less malicious, but present nonetheless. Amy recounted a conversation that she had

with one of her staff during a routine performance appraisal. The staff member, at the end of the interaction, was shocked that the conversation had gone so well and had been so engaging. So much so, Amy recalled, that the staff member commented that she "didn't realize I was so normal." I suppose that one could suggest that this comment was completely innocuous and that the staff member did not mean to imply anything other than that she had found Amy more personable and approachable than she had anticipated her being prior to entering into that conversation. While this may be the case, that comment still struck me. Of course Amy was normal. Again, she is a human being, and not a foreign life form, or a management robot that has been sent into the lives of her staff to wreak havoc and destruction. However, perhaps this declaration of normalcy was more of an expression of the othering of NMs. Amy was not in the same role as the employee that made this observation, which seemed to lead that individual to believe that Amy was fundamentally different; due to the challenging nature of their jobs and the different type of work that NMs are responsible for, perhaps it is not possible for staff to view them as being the same as them, despite the shared RN designation. Whether positive or negative in the connotation that such a belief may carry, it serves as another thing that separates NMs from the staff that they supervise, another thing that makes NMs a little bit less human, and a clear division that arises from the role transition.

**Tall Poppies and Bullying Behaviors**

With a laugh, Sarah stated, "I have been, at times, bullied by my own staff." While the chuckle that was attached to her statement may have softened the blow of those words, it was nonetheless both unusual and troubling to hear. The notion of bullying within the nursing profession is nothing new, with the expression, "nurses eat their young," used to describe the abusive dynamics that often exist; the classic illustration of this adage being the hardened and

wise senior nurse being unnecessarily tough on the wide-eyed, struggling new graduate, until the new graduate has sufficiently proven himself or herself. The bullying behavior that plagues the nursing profession is also known as horizontal violence and is defined as hostile or harmful behavior from one employee towards another in a lateral position (Purpora, Blegen, Stotts, & Faan, 2012; Taylor & Taylor, 2017). Horizontal violence may be seen through behaviors ranging from subtle forms, such as eye-rolling, sarcasm, and speaking in a condescending tone, to more overt forms such as gossiping, applying unwarranted scrutiny, name-calling, belittling, and physical assault (Purpora et al., 2012; Taylor & Taylor, 2017; Weinand, 2010). The terms bullying and horizontal violence were used interchangeably, with both terms describing the same behaviors and patterns of interactions. Sue described the vulnerability that she felt in her position as an NM, in particular, because she managed unionized staff. She explained the feeling of being under scrutiny from her staff and felt the need to take steps to protect herself.

> *You feel you have to be careful and you have to tread lightly. Like you almost have to document all the situations that happen because if they ever bring union in, you need to have your side of the story as well. You felt like you were kind of walking a tight rope sometimes.*

Sue was not the only participant to feel this way – Amy, Alex, and Sarah all described similar feelings, that their staff were watching for them to make a mistake so that they could "report them." At times, it felt like a threat that staff used to intimidate the NMs, preventing them from addressing issues or performance concerns.

In the literature, NMs were included not as potential victims or an oppressed group that was at risk of experiencing horizontal violence, but rather as likely perpetrators or as holding a responsibility to shift the culture of the workplace away from accepting such behavior (Armmer

& Ball, 2015; Purpora et al., 2012; Taylor & Taylor, 2017). While I do not disagree that it is possible for NMs to bully staff, and that NMs are responsible for creating and maintaining a workplace that does not tolerate or condone bullying, NMs are entirely capable of experiencing the negative impacts in the same way as frontline staff. Perhaps the challenge in recognizing this potential lies in the fact that NMs are not in lateral positions to their staff, and therefore, we would anticipate that they would not be vulnerable to such attacks. A potential explanation for this type of upward-directed bullying was provided by Donovan, Diers, Goodrich, and Carryer (2012) in their discussion of tall poppy syndrome. Tall poppy syndrome is defined as bullying behaviors that are specifically directed towards high performers in an attempt to disparage their successes and normalize their achievements (Donovan et al., 2012; O'Neill, Calder, & Allen, 2014). This pattern of behavior helps to provide an explanation as to the occurrence of some of the challenging behaviors that were encountered, but does not dampen the reactions of Alex, "every day I'm a little bit shocked by the things that go down," and Sarah, "I would never talk to my boss this way. And why is it okay for other people to talk to me this way?"

A common thread exists between horizontal violence and tall poppy syndrome, which is the challenging behaviors that victims experience. My participants described a range of interactions with their staff in which they encountered upward-bullying which aligned with the definition of tall poppy syndrome. Amy described a recent experience with her team:

> *I'd say my manager is the good guy and I'm the bad guy at one of my sites. And they have tried recently to trash talk me to my manager. So that's fun. I think they're insecure, so, I just have to keep that in mind.*

Although NMs are in a position of power, they are RNs, and share the same professional designation as their staff. Perhaps this similarity enables staff, whether consciously or

unconsciously, to perpetrate bullying behaviors and actions towards NMs. I considered Sarah, who now manages the team of which she was once a part. She is simultaneously no longer a part of the team of which she was once an integral member, yet the memory of her as a colleague likely lingers with her staff. While she is clearly in a position of authority, the memory of her on the frontline does not fade immediately, and perhaps some fail to see her as fully integrated into her NM role. Sarah described her ongoing struggles in how she had been treated by her team.

> *I've had a lot of issues with my staff . . . we were trying to get his [*HR*] help for some issues we were having with our clinicians, and I was telling him about how my staff were talking to me and that I was getting yelled at.*

An alternative consideration of bullying directed towards NMs from frontline staff is that staff perhaps see their NMs as a tangible representation of the oppression that they have experienced in the nursing profession, the issues that exist in their workplace, and the challenges of the larger health system.

Taylor and Taylor (2017) stated that bullying and horizontal violence is so deeply ingrained within the nursing culture that many nurses are not aware when they witness or are victim to such behaviors. There are several explanations as to the prevalence of bullying in the nursing profession; these include the predominantly female workplace and related oppression due to gender, the oppression of the nursing workforce, intergenerational differences, hierarchal nature of the nursing role, and feelings of powerlessness experienced in nursing (Farrell, 2001; Purpora et al., 2012; Weinand, 2010). Horizontal violence and bullying are cyclical problems, in that those who are oppressed or mistreated typically go on to mistreat others. This is a result of the victims of such treatment beginning to identify with their oppressors and adopting similar ways of thinking (Purpora et al., 2012; Weinand, 2010). The impacts of the horizontal violence

experienced in the nursing profession are far reaching and can bring forth negative consequences including decreased quality of patient care, increased staff turnover and attrition, and decreased physical and mental health of nursing staff (Armmer & Ball, 2015; Purpora et al., 2012; Taylor & Taylor, 2017; Weinand, 2010).

## The Loneliness Challenge

The literature on role transition addressed the challenges associated with moving from frontline nursing into an NM position, with one of those challenges being the loneliness that results from this career shift (Weinstock, 2011). Prior to becoming an NM, I knew that the social aspect of my job would change considerably. I knew that the nursing staff that I managed would not be my friends the way that the colleagues I worked with in frontline nursing were. What I did not consider was that this shift in the relationships that I experienced as an NM would feel the way that it did. The participants that I spoke with also acknowledged this same feeling of being the outsider with the staff that they were managing, and of feeling a shift in how they related to the nurses that they were managing. I thought about why this was, and what it meant from a relationship and social perspective to be frontline versus to be in management. To use the example of a frontline nurse working on an acute care unit, on any given shift, he or she is typically interacting with a team of 10 to 15 peers that spend up to 12 hours together, working together to make it through what can often be a challenging and demanding day. The nurses that work together on an inpatient unit often feel more like family, like a support system that is there to help get you through extremely difficult days and scenarios. They are frequently each others' confidantes and friends; they understand each other in a way that few can. This is a group that shares the same profession, that has been through the same challenges, and is often extremely tight-knit and close.

The way that frontline nurses connect and relate to each other led me to consider Gadamer's notions around community. To belong to an inpatient unit or team of frontline nurses is to belong to a community. People find meaning through belonging to community and it is through a sense of membership and belonging in these groups that people are able to establish values and decide right from wrong (Gadamer, 1989). Understanding is established through seeing oneself as a member of a community; it is through this identification that one is able to build relationships, establish common language, and determine where his or her prejudices may lie in relation to the community (Gadamer, 1989; Hammermeister, 1999). Deciding to move from frontline nursing into an NM role means that one must leave their original community, and the place where they have formed their current beliefs, values, and understanding of the world. Not only does the new NM have to reconcile a new professional identity, as was discussed in the previous chapter, they must now also establish a new sense of community based on the change in their role. This shift in community for the new NM means that their whole sense of understanding must also change; as an NM, there is a different set of priorities, a different way of making decisions, and a different way of relating to frontline staff. The prejudices that were established as a frontline staff must be challenged and addressed because for the new NM, and life as they know it has shifted.

Alex had worked in the same clinical area since the acute care center she worked at opened several years ago. Naturally bubbly and friendly, you could see that she was able to connect with and relate to people with great ease. Being with her previous team since the beginning, deep roots were established in her professional relationships; she knew her colleagues, what was happening in their lives, and they knew her. Alex had acted as the covering manager on her own team for brief periods prior to settling into a permanent NM role in

a new clinical area. She discussed how the nature of NM work changed her social dynamic at work.

> *When I was on the floor, those nurses, you know, I still talk to all of them, and we're super tight and knew all about their personal lives and you really connected, but it's hard to find that kind of connection in this kind of role. It's different…You kind of put yourself out there when you're in the manager role, you leave the group of people that you've worked with, right, and you're kind of solo, and have to tell people things that they don't want to hear and so that's kind of risky socially.*

The network of other managers that an NM encounters is comparatively small, and he or she often works closely with only a few others. Strictly based upon numbers, it is easy to see how the professional-social circle of the NM has the potential to shrink greatly, regardless of the significant change in the nature of work. Added to this is the need to establish boundaries with frontline nursing staff, who, for the new NM, is the group that he or she is often most readily able to relate to. Weinstock (2011) and Mackoff and Triolo (2008) noted the importance of establishing boundaries with staff, as many of the tasks associated with the NM role require difficult conversations, objective decision-making, and fair and consistent treatment of all staff. All of these role requirements are made considerably more challenging if the NM were to have personal relationships and friendships with the staff that they were managing. While Alex was clear in acknowledging the isolating nature of the NM role, she found a sense of relief in managing a team of which she was not previously a part.

> *Even though I didn't know the area at all, never worked in it as a nurse, I actually found that job easier than where I covered in my own area because, you know, I had a chance*

*to start fresh, people didn't know me, and I could lay out my expectations and it wasn't that awkward.*

NMs that I spoke with could appreciate a sense of loneliness that resulted from their role transitions, however, this existed on a spectrum from being relatively subtle to jarring and obvious.

Amy, who is now managing a team that she used to be a part of as frontline staff, discussed taking a more deliberate approach to changing the relationships that she had with her former colleagues. She had anticipated eventually stepping into a managerial role with her team, and as such, had prepared for the shift in relationships that was sure to occur in advance.

*I think I almost kept in mind that I need to stay professional with them all the time, because this wasn't my lifelong goal. To stay a case manager with them. I was gonna do something else, and I wanted to make sure I hadn't burned any bridges or done anything inappropriate that they could flip on me.*

In discussing what the social interaction is like now, she stated that she now declines invitations for lunches with her previous team, noting the difficulty when "things start getting blurred." Amy and Alex demonstrated another dimension of the role transition, one that suggests that the distance and isolation is not only a by-product of the new role. Creating distance and boundaries with staff can also be seen as a coping mechanism, used to make it easier to carry out the difficult tasks that are associated with managing people, or that the job is made easier when you are less connected. Being an NM involves making hard decisions, relaying unpleasant messages, and asking people to do things that they may not want to do. Perhaps these tasks are made easier when NMs can view their staff as "the other," in the same way that, at times, NMs may feel they are viewed by their staff.

Some of the things that are most taken for granted in a workplace are the things that new NMs may find themselves to be missing as they settle into their new role and professional identity. Things like having someone to take coffee or lunch breaks with, someone to joke with, or a standing invitation to social meetings that occur outside of the workplace may all become scarce in the early days of being an NM. Even now, having settled into my role, I recognize the absence of some of these things in my new professional life. It is not uncommon, even today, for me to shut the door to my office and eat lunch at my desk, because it does not seem worth it to go to the cafeteria and dine by myself. Alex discussed the moments where she finds the role lonely and explained the feeling of not being involved in the everyday conversations that occur on her unit, "everybody's laughing and joking and you walk up and they all stop. Like, I like jokes too, you guys!" Something as simple as being left out of the joke, or feeling the conversation come to a distinct halt when you walk up is a feeling that is uncomfortable and has the potential to be isolating for the recipient of this conversational exclusion. Lisa, another NM that now works in a new area, compared the realities of her new role socially with what she was used to, coming from a very tight-knit team, "you don't get to go out every Friday for the safety rounds, it's just not part of your role. So, if you can have those connections, it's important, because it is a bit isolating."

While it is expected that relationships with staff and former colleagues have the potential to shift and evolve, it is nonetheless human nature to feel surprised, hurt, or confused when these changes occur. Sarah talked about a moment where it became very clear that her social relationships had been drastically altered. While she was challenged with the interactions that she had with her staff, the following occurrence made a bold and cutting statement:

> *We had a social committee Facebook page, and it was only about social stuff, so and so's getting married or let's go for wings, whatever. Nothing work related was ever put on there, that was like a strict guideline. But I got removed from that group. Instantly relationships changed.*

I found this recollection interesting for a couple of reasons. This was not a subtle case of an individual's former team slowly phasing them out socially, or a gradual drifting apart of previous relationships as one settles into their new role. It is not a case of someone assuming that things have changed, or that they are no longer as close with their former colleagues as they once were. It is clear, and it was a conscious choice to remove her from this online group. Someone decided that because she was an NM, she was no longer allowed to partake in that aspect of the work environment any longer. This story again drew me back to Gadamer, as Sarah was again separated from her community. Not only had she been separated from the change in role, but now she had been separated by being removed from an online gathering place, an area where information was disseminated and shared, and where community members communicated with one another.

There was no discussion, no warning, and no consultation into how the NM might feel about this choice. In saying that, I ponder whether that would have made a difference. Had Sarah been told or consulted that she was being removed from the group, it is not to say that it would have stung any less. Likewise, perhaps it would have made it more painful, or more uncomfortable to talk about what was to happen. Through experiencing role transition, one does need to leave their previous community, and perhaps Sarah's previous community deciding to take her out of the unit Facebook group was simply a measure of them acknowledging her new role and their awareness that things had changed. The other thing that I find interesting about

this recollection is the role that technology and social media now play in socialization and workplace culture. There was a time when if someone switched roles in this manner, they would likely no longer be involved in planning events or brought into social conversations, however, now there is a tangible community from which a person can be removed should they step outside of the definition of that community. This example again brings forward the expectation that NMs have a thick skin and would not be wounded by this type of treatment from one's former peers, friends, and colleagues. Although perhaps warranted and appropriate, it is hard to not respond to yet another reminder of the professional identity shift that is underway and associated with this role transition.

**My "Secret Friend"**

Perhaps the most startling admission of loneliness came from an NM that told me about her "secret friend." Sarah, who prior to becoming an NM was well connected and respected in her team, discussed a friendship that had survived the role transition. Sarah and her colleague had worked together for a number of years, had children the same age, and shared many common interests outside of work. Beyond a work relationship, they had also developed a deep and meaningful personal friendship. When Sarah became an NM, it was as if an invisible line was drawn in the sand. Sarah and this friend no longer socialized at work, they no longer brought each other up in conversation, and they no longer acknowledged instances where they spent time together outside of work. Despite the friendship remaining intact, and the relationship between the two outside of work staying more or less the same, it was not a relationship that either was willing to acknowledge while at work. Without discussing that this would be the case, or why it would happen that way, the two carried on their friendship, however, kept it entirely hidden from the workplace.

> *One of my friends, we decided, we didn't even talk about it, we became like a secret relationship. So, we don't ever post pictures of each other on Facebook. Like, she came with me to the CARNA [*Canadian Association of Registered Nurses*] gala when I got the ARNET [*Alberta Registered Nurses Educational Trust*] award, but she just took pictures of me, there's no pictures of her. And everyone was like, "oh did you go with your husband?" And I'm like, "no, I just went with a friend." And it's so funny how we talk about it, and we're like, "I don't know why, I just thought it might be awkward for you" and she's like, "I just kind of thought it'd be awkward for you too"…So we're secret friends.*

The notion of a secret friendship is incredibly compelling to me, it is something that I simultaneously understand and feel saddened by.

This friendship became a secret seemingly based upon mutual consideration and worry that the relationship would create awkwardness or tension following Sarah's transition to NM. Both parties recognized the need to renegotiate boundaries based on Sarah's new role, as they stated to each other when discussing the change in their relationship, however, an aspect of this friendship had to be let go in order for the two to feel able to carry on the relationship. Sarah described a moment where both acknowledged the state of their friendship and both had the same explanation, "I thought it would be awkward for you," referring to if they were to continue with a public friendship. To avoid scrutiny from frontline staff and colleagues, I can see why it might be good to be inconspicuous about that relationship in public. On the other hand, the idea of a secret friendship does not seem quite as pragmatic and reasonable when one considers the reasons why it must stay hidden. Aletheia seems to be at play when considering the evolving relationship between Sarah and her secret friend. The relationship that once existed between

them has been concealed, while a new relationship and a new way of being in their relationship is unconcealed. Previous understandings and ways of connecting with each other must give way to a new way of interaction and connection that is adaptive to Sarah's new role and the new community that she has found herself in. While for Sarah, it is a means of not creating additional professional challenges in an already difficult role transition, for her friend that is concealing the friendship, it seems somehow more sinister. I asked Sarah whether no one questioned what happened to their relationship as they were friends before, and she responded that people likely assumed that her secret friend had cut ties with her, in the same way that all her other previous coworkers had.

While Sarah did not acknowledge it as such, I feel that must have been hurtful, to know that the reason that this friendship was able to carry on without question was the widely held belief that all of her previous coworkers had moved on, and therefore, so had the secret friend. The secret friend has remained a part of the old community of to which Sarah no longer belongs, and perhaps it is not acceptable that the secret friend sees Sarah as anything other than the boss. I also think that it must feel extremely isolating, to have a good friend in the workplace, and to have to carry on the act that the relationship does not exist, to not be able to share a laugh in the hallway, or to sit with them at lunch. While in part, I know this is a mutual choice, a division has occurred, and Sarah's secret friend is on the other side, at least at work. In the workplace, where people spend a great deal of their time, the secret friend gets to carry on relationships with other colleagues, unaffected, because they do not know that she is still Sarah's friend. The same cannot be said for Sarah, who feels as if she has been marked, cast out, with the directive that it is not acceptable to be nice to her, and it is no longer normal to be her friend.

Sarah's mention of a secret friend had captured my attention, which lead me to consider the phrase, and more specifically, the word secret. By definition, the word *secret* refers to something that is not meant to be known, and drilling down further, to the etymology of the term, secret denoted the need to separate or set things apart (Google Dictionary, n.d.). This suggests that there may be another side to having a secret friend, that it is not an act of betrayal or shame, but merely the separation of the friendship from its previous context. With the transition into the NM role, Sarah has assumed a new professional identity, she has new responsibilities and obligations, and she is finding her way in a new community. Perhaps this all suggests that with all of that change, her previous friendship had to change in order to survive, it was not meant to be seen by others. Although the relationship may have stepped into a place of concealment, it has survived, and has undergone transition in the same way that Sarah has.

**Transitions that Lead to Loneliness**

It is not to say that the transition into an NM role is a measure of social ruin, or that anyone that undertakes this career step is certain to be isolated and alone, silently eating lunch in their office, having not spoken to another soul in days. It is, however, a significant change from the level and type of interaction that many NMs were used to when they were in their frontline nursing careers. While some have the foresight to prepare themselves for this change, and while all that I spoke with could understand the necessity for their relationships to change and for boundaries to be established with their direct reports, it still feels lonely sometimes. It is natural to seek connection with other humans, establish relationships, and have conversations. This is true of the nursing profession as well; it is a human profession defined by caring, and dependent on compassion and the development of relationships with colleagues and with patients. I think that the experience of loneliness in the role is not surprising, giving that such NMs were once

nurses and did work that was heavily based on relationships, interaction, and connection. With the shift in identity and the change in community that occurs with the role transition, these connections do not always come as easily as they once did, but given the importance and business of the NM role, perhaps others do not always appreciate the loneliness that NMs may experience. The expectation of NMs being able to take tough criticism, and to accept being unpopular among frontline staff as a part of their job contributes to the feelings of loneliness that can fester in this role.

### Learning the Balance of Consistency and Being Emotionally Responsive

Despite NMs being members of a distinctly caring profession, the role provides obstacles in terms of being able to act in a truly human, emotionally responsive capacity while carrying out the duties of the job. One of the first pieces of advice that I received when I started as an NM was to be consistent; the surest way to be successful in managing people was to ensure that you treated everybody the same way. Additionally, an important piece of advice was to know my collective agreements, given that I was managing a unionized workforce, and to ensure that I followed them stringently. Collective agreements provide a set of rules for employers to follow in managing unionized staff, to ensure that employee rights are protected. The guidelines serve as a decision-making tool, particularly in challenging situations in which the interests of the employer and the employee may be at odds. Not only are these some of the earliest pieces of advice that I received, but they are encouragements that I hear time and time again from my colleagues, and they are pearls of wisdom that I have also offered to colleagues and peers when sharing in lamentations about the challenges of being an NM. By taking up this dedication to consistency and fairness towards all of your staff, the NM protects himself or herself. If you follow the collective agreement, your staff are less prone to oppose decisions that you make, and

if you treat everyone the same, you do not ever find yourself caught in an allegation of favoritism. Furthermore, one might argue that being consistent and fair is the right thing to do.

While this advice is valid and logical, and were words that I have lived by throughout the early days of my NM career, they do not always lend to being human. The desire to behave fairly, to have certainty, and to know what decision needs to be made are definite aspects of being human; however, feeling unable to deviate from the rules or behave inconsistently when exception is needed, or feeling that following the rules means you are not doing the right thing, can make the NM feel unable to be emotionally responsive. Being consistent would indicate that an NM handles a situation in the same way every time, however, this approach ignores individual differences. Lisa discussed the difficulty in balancing consistency and individuality.

> *Every situation in this role is different, right. And, it is at the bedside too, just because two people have the same diagnosis doesn't mean you're going to react the same way, but it's trying to strike that balance between consistency and individuality. Because no two situations that you come across are the same, no background of the situation is the same, the two people in a situation are never the same, but you also want to strike that consistency.*

Being fair, steady, and consistent, dealing with human emotion, and making difficult decisions amidst exceedingly complex situations are all part of the NM experience. When an NM is trying to achieve a balanced budget, and has been told that in order to achieve the numbers that he or she is targeting staffing numbers must be reduced, and he or she must deliver that difficult message to the team that he or she is leading, the NM almost has to rely on that tough exterior be resolute in that action.

Allowing oneself to be emotionally responsive would mean that one would say that there was no way to ask staff to "do more with less," as NMs so frequently beg of their teams. Being emotionally responsive would mean that one might make an exception, just this one time, to help a member of the team who is in a tough spot and really needs it, even if it means bending the rules, just this once. Sarah discussed the constant tug-of-war between being consistent and following the rules and being empathetic and emotionally responsive to staff needs:

> *It's okay to be consistent, but sometimes you just want to give someone a break, you know. All these things have happened in their life and they happened to be late today and it's no big deal, right? But then you have to be prepared to let that go with everybody.*

This challenged me to think about what it means to be human and emotionally responsive, and I reflected on this in a journal entry. I considered the expectations of being an NM and the challenges that they may impose.

> *We often hear about the importance of being consistent, and this made me think that perhaps the opposite of being human is being robotic, and maybe we feel this is an expectation of the NM role. We think that we are pre-programmed with the rules and policies that we must follow, and that our system does not allow us to stray from these . . . To only follow rules, policies, and budgets forgets about the people, which are central to the RN and NM role.*

A strictly "robotic" approach fails to take into account the individual differences, and the changes in context. There is not a singular approach or way to solve a problem, despite the way that consistency is valued in the NM role, despite the ideals that we are taught, and despite the processes that collective agreements offer. Giving in to the desire to be a little more flexible and understanding might give way to countless unintended consequences, like failing to meet

assigned organizational priorities and therefore being ineffective in reaching goals, or being viewed by staff as a pushover who can be walked all over and taken advantage of in the future. As Sarah stated, if you make an exception for one, you must be prepared to make that exception for all, even in the cases when the situation does not compel an NM to respond with understanding and empathy. The new NM is not unlike the new graduate nurse; he or she is a novice in the role and has not yet learned the intricacies and nuances that come with the position. As such, he or she must rely on rules, policies, and established processes to guide decision making during the novice period (Benner, 1984). The new NM has not yet learned which rules they can break, which risks to take, and when it is acceptable to break the rules, make an exception, and be emotionally responsive to their staff. This knowledge comes with practice and experience, it develops as the NM advances their practice towards the expert level, and as they move through their role transition.

While NMs are still people, and still nurses who care, they are also managing within a health organization, and must be mindful beyond the day-to-day operations, to the business of keeping the system moving. Lisa further discussed the challenge of striking the balance between being firm in leadership decisions, and being human.

> *It's realizing the buck does stop with you. And you don't always get to be the nice person or the understanding person . . . You don't want to be a pushover and get walked all over but at the same time, you don't want to be dropping the hammer every five minutes.*

When so much of the role can be overtaken by the business of health care, it is somewhat understandable that the NM's teams and staff can forget that there is a human face that looking back at them and attempting to steer what often feels like a sinking ship. Not only are NMs asking their staff to "do more with less," they are asking the same of themselves, and feeling the

shortcomings of this plight. The anger and the frustration that is often catapulted in the direction of the well-meaning NM is perhaps simply a reflection of the fact that sometimes acting in the way that is fair, consistent, and right is not the thing that will please people, and not the thing that allows our human-ness to shine through. It is important for new NMs to find moments where, in spite of the obligations and accountabilities their role imposes, they can demonstrate understanding and support of the challenges that frontline staff encounter.

Alex spoke about one such opportunity, in which she was able to earn trust with members of her team, who were distressed about the staffing levels on night shifts. Alex recalled her early days on the unit, and how she ensured her staff felt they were being heard.

> *I could barely even introduce myself when I came to this job and I'd say almost half of them have come up to me and said, "you know, nights is terrible, this, that." So, actually, I worked a night shift with them and just wore my scrubs and helped them for the night to see what they were actually talking about and I think that honestly, that helped so much . . . I felt like I had to do this. I felt like I had to for them to actually believe that I cared, and to show it.*

What made this a measure of being human was that Alex chose to be responsive to the concerns of her staff. She could have could have shrugged and let staff know that there was nothing that she could do based on her budget. Instead, she tried to understand it from their view, and stepped out from behind her desk to work alongside them, to see whether the new understanding that the experience shaped would implore her to find flexibility or room in the budget. Another way that NMs proved themselves to be human was through humility and being open about the things that they did not know in their role. NMs frequently find themselves in their role as a result of being an expert in their area, or demonstrating strong clinical capabilities (Doria, 2015),

however, this proficiency does not always carry into the new capacity in which they are working. While NMs that manage in areas where they have previously worked have the benefit of understanding the clinical area that they are leading, they must still grasp the new skills required with the change in position. NMs that are managing an area that they have not worked as frontline are doubly tasked with learning not only their new management duties, but also gaining an understanding of the area where they find themselves. Alex and Lisa, who were both managing clinical areas that they had not worked in as frontline, stated the importance of acknowledging what they did not know, and seeing their staff as the experts. Alex stated, "I don't pretend to the staff that I know…and they've appreciated that."

### Coming Out on the Other Side of a Transition

In considering the experience of role transition up to this point, a great deal of my consideration has been around the aspects that relate to breaking down. One must leave behind their previous professional identity, become accustomed to a new way of working and being in the role, and leave the community that previously defined their existence as a nurse. All of these moves have considerable challenges attached; they are not without difficulty, require patience and personal development, and at times, can be extremely perplexing to the individuals that are working through the transition. However, from this comes the triumph of transition, the moments of beginning to rebuild, of starting to understand one's new role, and of beginning to taste success and achievement within it.

> *I like talking to people and getting to know them and figuring out how things worked. And I liked learning an area that I hadn't worked in before. I found that rewarding, just to broaden my own horizons on what's out there.*

As Alex reflected back on why she took on the role, she was able to appreciate the successes that she had experienced as an NM.

> *I think you can actually make an impact in a role like this. More so than just ticking off a list of things to do and really making no system changes, but in a role like management, you can still get out there and help on the floor if you want and talk to patients. But I like being involved in the processes of things and you know, looking at the hospital as a whole versus just your patient assignment . . . There are more days where I'm like, "this is good," everybody is working, and I see good things, and I've had a few successes.*

Beyond simply feeling more confident and being able to see value in the work that they are doing, the new NM must also find a new community as they move through the role transition.

This community will help to shape their understanding, provide support, and enable their ability to move towards proficiency. For Lisa, establishing a new community in her management team provided an assurance of support throughout her role transition.

> *The group that I'm in is very supportive and very helpful and very willing to answer whatever they can or jump in to help you if you need it. I found that really helpful and I think it made a huge difference. It was a really good experience in that way, supportive co-workers, and the team was really supportive of me trying to figure things out and figure out which way was up.*

In rebuilding through role transition, coming to a place of contentment involves establishing and accepting a new normal. The idea of establishing the new normal related, for me, to the forming, storming, norming, and performing theory of team development (Tuckman, 1965). The upheaval and experience of transition experienced by new NMs relates to the storming phase, in which old ways of understanding and doing things are disrupted, often accompanied by conflict and

emotional challenges. Team members, or in this case, new NMs, must move through to the norming phase, in which new standards are established and a sense of cohesiveness is attained, ultimately enabling the individual or team to advance to the performing stage, in which needed tasks may be performed (Tuckman, 1965). The idea of norming also tied to the maturation phase, in which NMs are able to appreciate positive impacts in the work that they are doing, and gain a sense of feeling settled in their roles (Luo et al., 2016).

## Concluding Thoughts

There is a clear tension in existence between being an NM and being an RN, one that is experienced by the NM themselves, and the way that their staff relate to them. Additionally, there exists a tension between stepping up to the demands of the NM role in spite of remaining a member of the nursing profession, and still identifying with one's self in this way. The difficulty in establishing healthy relationships and boundaries once in a new role was experienced by several participants and was a challenging aspect of the role transition that also stood clear in my personal recollection. When I look back at some of the moments that I found the most disheartening in my early days as an NM, I can appreciate the ways in which nurses treat each other are deeply ingrained within the culture of the profession. There are forces at play, often without conscious intention or realization that impact the way in which nurses treat each other. An NM is still a nurse, and therefore, it seems impossible to expect that they may be immune to these profoundly imbedded maladies that plague the profession. However, it is not all bleak, in that the NM's identity as a nurse is also what enables to them care about the work that they are doing and the people that they are managing, it is what enables them to approach the role with a vision for improvement and quality care, and not just numbers, figures, and balanced budgets. In a sense, I think of navigating these challenges as being the turning point in role transition – at

this point, the new NM reaches a point of breaking down, and of great difficulty. However, from here is where the NM may begin to rebuild and advance through the transition, towards moments of success, towards a sense of contentment, and a feeling of integration and belonging into a new community and identity. This is challenging and failure to rebuild, and to make it beyond this point in the transition process, is reflected in the high turnover of new NMs.

## Chapter 6: The Overwhelming Need to Do it All

> *There's just so many things you have to do. You have to exercise, you have to eat your vegetables, you have to watch how much wine you have, you have to be positive around your kids, you have to not say too many negative things, you have to teach them diversity and tolerance, and all this stuff while trying to model the behaviour, and work on your masters, and go to school, and pay bills, and everything like that.*

Sarah let this all out in one breath, the words simultaneously rushing out, and piling on top of one another. The list of responsibilities and expectations grew, these things weighing upon Sarah, as she lamented the need to get it all done. This reflection was a result of asking Sarah how she was able to balance the responsibilities of her new role with her personal life, and this was her response, communicating that she had not figured that part out yet, because the added work of being an NM meant that she had to figure out how to fit it all in. High demands of time and energy have become the norm for NMs, causing these individuals to be susceptible to work-related stress and fatigue, which may contribute to negative outcomes including decreased health and well-being, attrition and turnover, decreased quality of care, and poor staff satisfaction (Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010; Steege, Pinekenstein, Arsenault Knudsen, & Rainbow, 2017; Udod, Cummings, Care, & Jenkins, 2016).

In the forthcoming chapter, I will explore some of the challenges that participants experienced within the NM role, specifically looking at the seemingly impossible duties that they find themselves tasked with. I will explore the way that one's personal expectations, paired with unclear definitions and understandings of NM work, can contribute to feeling overwhelmed and, at times, unsuccessful. These aspects of the NM role contributed to participants struggling to

establish a healthy work-life balance and establish personal and professional boundaries. While these challenges may not be unique to the NM role, what does set the experience of these difficulties apart is the fact that they are so different from the challenges that may be encountered at the bedside. Not all NMs set out on their career journey with ambitions of leadership; these roles sometimes find the person rather than the other way around – this was certainly true for myself and for some participants. Perhaps this contributes to the shock of these challenges, as well as the unique tension that NMs experience of being pulled in multiple directions, feeling pressure from their teams and staff, while simultaneously experiencing similar pressure from above.

## Leaky Faucets and Impossible Tasks

In the conversations I had with participants, I endeavoured to explore their experiences with role transitions, and inevitably, both the dialogue that occurred with participants and the understanding that my resultant interpretations shaped for me, required contemplation of the shift in professional identity that accompanied their moves into the NM role. I considered what parts of the participants' identities were tied to being nurses, and how this professional identity evolved in order for them to be successful and become the other, fully assuming their NM roles. Something that all participants spoke about, in one way or another, was the infinite nature of the NM role. They shared the feeling of never being able to "get it all done," the feeling of powerlessness towards things that they could not change, and struggling to re-establish a sense of work-life balance following the disruption and change that taking on a new role had caused.

While being a leader in any industry is undoubtedly challenging, there is an added complexity to being an NM and managing in healthcare that make the stakes feel very high. The

outcome of one's success as an NM does not just impact organizational outcomes, but it impacts human lives, it impacts illness journeys, it influences wellness, and can be the difference between life and death. Not only are the stakes high, but the NM exists in a system that is often in turmoil, often feeling under-resourced and over-stressed, and constantly faced with wicked problems. NMs remain in tension between their two roles, the frontline nurses that they were previously, and the leaders that they are becoming. The fusion of these two horizons makes the NM role difficult; the challenging work that NMs are doing is complicated by the context of their history, their prejudices, and all that they know from being frontline staff. It is difficult for the NM to make a decision as a leader without it being influenced by their identity as an RN, and in the early days of the role, NMs have not yet settled this shifting identity, they are in flux, and trying to figure it all out. In the same way that Gadamer acknowledged that we could not ignore our prejudices and our history (Gadamer, 1989; Zimmerman, 2015), NMs must be aware of how their history and prejudices influence their new identities as they work through the tensions of this role and the many competing priorities that they will encounter.

**Impossible Tasks**

Alex coined the term, "impossible task," when describing what her workload was like as she reflected on how the first five months in the NM role had gone for her. NMs are frequently pulled in multiple directions and must attempt to balance the demands of their role, organizational priorities, and staff expectations, all within the context of a bustling and chaotic workplace rife with frequent interruptions (Udod et al., 2016). Alex expressed feeling powerless, and like her role required her to do the impossible, and achieve things that could not be achieved, both from a resource and a time perspective.

> *My list of things to do is so gigantic that I never get it done. Ever. I've learned that I used to function in my nurse educator role that everything was done on time and I had my priorities and I'd get it done and then leave. It is impossible in this role, so I just have learned to let go . . . I'm like, "you know, I had 10 urgent things to do today, I got three done." That's what I feel like every day . . . It's like, you're overcapacity today, there's a code and three sick calls. So, you're trying to wrap your head around that, and there's very little time to actually figure it all out, because it doesn't stop . . . There's so many tasks to do, that it is actually impossible to get it all done, and I don't know how to do half of them . . . I feel like from every direction. I mean this department wants to meet with me and start an initiative on our unit, I'm leading a [*quality improvement] *project coming up, which got dropped on my desk, and there's another zone-wide [*quality improvement] *project, and there's all these things and everybody that's working on these projects, it's their priority, but I'm spread…like they have* ***this*** *much of me.*

Alex sighed as she said this, and held up her hand, showing a tiny amount of space between her thumb and index finger, denoting what little she had to give to the many things that were being asked of her. I could sense the exasperation that she felt, in the constant struggle to keep up, knowing that the goal was no longer to finish her work, or have things wrapped up in a tidy package. It was just to do what she could, and make those things her priority, accepting that there were things that were going to wait, that were not going to get done, and were not going to be the recipient of that space between her thumb and index finger. Shirey, McDaniel, Ebright, Fisher, and Doebbeling (2010) recognized the stress that impossible tasks can impose on NMs, related to feeling that there were not enough hours in the work day, feeling powerless to

overcome the challenges that they were faced with, and the constant tension of being pulled in multiple directions towards competing priorities.

In frontline nursing, there is a sense of completion and accomplishment within a shift, or within a work week. Lisa related to the never-ending list of tasks that were her responsibility as an NM and compared this to her frontline nursing position.

> *As a clinician, I'll have a list of 100 things to do, right? But if I don't get to them by the end of my shift, maybe I stay for a few minutes to try and tie something up, if it's been something that I've been dealing with. But it's a 24-hour business, so you pass it off. And then you might be gone for three days, so the next time you come back, it's probably been completed, or dealt with, or resolved. Whereas in this role, you close up your stuff for the end of the day, and it's at the top of your list for tomorrow…it's daunting, because the other things pile up behind it, and your list just keeps growing.*

For frontline nurses, when the day is done, they go home, and the nurse that relieves them picks up where they left off. Lisa summed up the comfort that exists with this notion, knowing that she would be returning to her frontline nursing position, "it will be nice to come to work and just worry about the shift that I'm on, the 12 hours that I'm here, and then go home." One does not come back the next day to the same work waiting for them. At the end of your work week, frontline nurses step into their days off knowing that when they do return, things will likely be very different, the patients will have changed, and problems will have been solved. This is not the case as an NM, because in this role, they are the solver of the problems, and there is no one that continues on their work when they go home at the end of the day or the end of the week.

**The Leaky Faucet**

It was not just the impossible task of making it through a never-ending list of duties and responsibilities that the NMs I spoke with faced; at times, they felt as though they were asked to do the impossible. NMs are made to feel that they should have the innate ability to fix wicked problems for which there is no easy solution; they should know how to fix problems that are complex and longstanding, regardless of their lack of experience or preparation for the role that they now find themselves in. Wicked problems are complicated and multi-factorial, influenced by the context within with they occur, unpredictable behavior, and a lack of a clear and agreed upon solution (Cleland, Patterson, & Hanson, 2018). These types of problems resist correction and are not responsive to the application of logical, systematic solutions (Cleland et al., 2018).

One such example that was addressed by participants were the fiscal constraints of the current health system. They felt that they should know how to stretch a budget that is already pulled so taut it seems there is not even an inch of give left, and they should know how to do so without ruffling the feathers of their teams. Alex discussed the feeling of coping with this pressure and recognizing the strain that it put on her staff.

> *I see where they're coming from. I get it. Sometimes I think our system is asking for us to do more with less. They're supposed to do more. But you know at the same time, at our budget meeting yesterday, you know you have to cut. I struggle with that . . . I feel completely powerless…we're kind of given the impossible task.*

Like Alex, Sarah had also encountered this impossible task, and recognized the same pressure to be able to operate her area with fewer resources, with a tighter budget, while asking more of her staff. Sarah gave an example of trying to meet the budget target she was given, while aligning

with the organizational mandate around the amount of positions she was required to operate with, in the presence of creating a staffing rotation that was considered compliant under the nursing collective agreement. But there is more; Sarah was also trying to balance the preferences of her staff and make them happy amidst the work that she was doing.

> *I struggle with wrapping my head around [*the budget*], because it might tell you how many FTE [*positions*] you should have, but can you build a compliant rotation based on that FTE? Maybe not…I swear half my unit wants to drop their FTE [*reduce to part-time*], and because I can't, I have two grievances from staff that are challenging. I wish I could give them part-times.*

Despite her best intentions, Sarah could not meet both her organizational priorities and the preferences of her staff.

Sarah detailed an analogy that described the impossibility of eradicating these problems, comparing this aspect of her work to a leaky faucet. When a leaky faucet is discovered, the hope is always that by fixing the pipe it is connected to, the problem will be solved. Unfortunately, the solution is rarely found that easily; rather, this often leads to a new leak in the pipe and fixing one leak often means that there is another that one that will appear downstream, which has the potential to carry on and on. Another analogy to the ways that NMs engage in problem solving was that of "putting out fires," and was a phrase that was used by several participants in their discussion of the challenges and unpredictability that their role offered. Udod et al. (2016) discussed this reactive method of attending to problems and challenges that were encountered in the NM role, responding to urgent concerns after they occurred. The idea of putting out fires held the same connotations as that of the leaky faucet; both relate to the desperate need to settle

emergent issues, that, left unattended, have the potential to lead to catastrophic and devastating outcomes.

Attempting to solve problems and seal up the leaks led Sarah to a realization about the realities that accompanied her role as an NM.

> *I had to change my perspective. I used to think "when things get better here, when things get better," and now I think, "what is the issue at the current time?" Because it's never going to be perfect . . . And I think of it like the leaky faucet, I fixed one leak, and now I have anther one that sprung up, how am I going to deal with that? Because thinking, "ok, if I can just get the staff to be happier, or to like me, morale to improve, things will be better," but then there's a new problem, and I'm learning to accept that.*

Accepting that it is not always possible to completely solve a problem, or to find the ideal solution that will be pleasing to all parties involved, is not only a reality that accompanies the NM role, it is a necessary to survive. The people that find themselves in the NM role were typically high performers on the frontline, constant achievers of excellence, doers of good, and knowers of all (Doria, 2015; Titzer et al., 2013). NMs were often the best at what they did clinically, and that is how they have come to occupy the role that they are in. With this in mind, it is significant that Sarah is able to accept her unit as being imperfect, and to know that she might not get exactly what she is seeking to achieve. NMs must be willing to grapple with this imperfection and be persistent in continuously fixing the leaky faucets that they encounter.

## NM Expectations of Self

Being able to accept the parts of the NM role that are imperfect, and that at times may feel completely disorderly and chaotic, led me to consider how this may impact upon the

personal expectations and standards that NMs hold themselves to, and how these things may affect their self-image. The nature of the work of being an NM offers significant challenges that can make new NMs feel that they are not good enough and are not achieving success in their role. Alex agreed with this, saying, "I feel like I'm still a brand-new nurse in my mind, like I just started with this." Perhaps the last time that new NMs had experienced such uncertainty was at the beginning of their nursing career, as new graduates, novice RNs that were struggling to find their footing, gaining the knowledge and experience that would eventually lead them towards expert status. Participants made it clear that they have needed to accept the fact that they will never be able to "get it all done" and that their to-do list never finds a point of completion; it does not end because by the time they have crossed one item off the top, three more have been added to the bottom. Additionally, NMs must accept that they may not be able to fix all of the things that need to be fixed. I contrast this to frontline nursing roles, where the nurse is the healer, the problem-solver, the one that helps patients navigate through their hospital stays and health issues. Of course, the NM is pivotal in terms of their influence on the health system and supporting their staff in providing care, but this is another aspect of their nursing identity that they must loosen their grip on. Frontline nurses may not possess the ability to fix everything in a day and have all of their problems resolved prior to quitting time, however, these issues do not wait for them. The collective nature of frontline nursing practice means that there is a teammate to take over when you go home, and there is someone to continue doing the work that you may have not been successful in making your way through.

Participants expressed that they did not always know what was expected of them in their role, and therefore, struggled to determine whether or not they were achieving success in the

work that they were doing. As such, participants not only needed to try and develop a new professional identity and determine what type of leader they want to be, they had to set their own expectations and definitions for proficiency in the NM role. Lisa described how she viewed the NM role when she first started:

> *It is a big role and it is a big deal and there is a lot to carry with the role. But I found, at first, it was almost like you single-handedly felt like you were carrying the entire thing, just on your shoulders.*

The definition of success in the NM role is fluid and varied; what makes a good leader to some may not resonate with others. Priorities vary between organizations, nursing units, and individuals, and therefore, doing really well at something only matters if you are doing really well at the thing that matters. Often, the NM must make unfavorable decisions and enforce tough realities. Doing so may mean that the NM is meeting the mandates set by their higher ups, but it may be at the cost of the happiness and approval of the teams that they are leading. If this is the case, it may be difficult to determine whether that NM is truly doing a good job. Success in this role seems to be in the eye of the beholder, and there is no universal definition of a good NM, nor is it always clear to the new NM whether they are doing the right things and meeting the expectations of their teams or their leaders. Sue vocalized this lack of clarity, and said:

> *It's a lot when you're starting into management from frontline…you don't even know what's expected of you, really . . . When I first started, I took my pager home with me, because I thought that's what we had to do. And then my boss said to me, "why are you taking that home!?" Because I thought I had to. She's like, "no, that's why we have admin on call." So, I think just knowing some of those boundaries as well, of what you*

> *have to do. Like what are the expectations, for your hours and your availability. Nobody really lays that out for you . . . I didn't know the expectations of that role . . . You do put a lot of pressure on yourself. And I think if the boundaries aren't set by someone else, we don't know what to do, what to expect, and, you know, maybe a different manager would have expected that you be on call 24-7. I don't think my boss expected that of me. That was definitely my own expectation.*

Participants discussed their uncertainty as to whether or not they were doing a good job, and their lack of clarity around what was expected, with Alex saying:

> *It's funny because I don't really know my expectations with it either . . . I feel like we're just supposed to magically know how to do all these things. And I don't know how . . . My manager now is super supportive and is happy with the work I'm doing and I'm meeting expectations, and so that is really important because I'm saying to her, "I didn't get this done," or, "I haven't done this yet." You know, I have this list of my own things that I should have done but I haven't done and she keeps reminding me, like, "actually you are doing a lot, and actually you are doing well." So, if I didn't have her, I would be panicked. Absolutely panicked.*

Sarah discussed the difficulty in garnering constructive feedback from her immediate supervisor and how it fueled into her uncertainty.

> *My manager's really good at giving me positive feedback, and so if I've done something really well, I know that. But it's the rest of the stuff, I guess. Or if I'm doing it wrong. And then I find because there's a lack of consistency at times that I'll think, "oh she'll*

*love this," but I get the opposite reaction. So, I'm trying to gauge when to bring something up.*

From these statements, it seemed to me that the NMs that I spoke with held themselves to high standards, with their expectations for themselves, at times, exceeding those that their immediate supervisors held for them. Perhaps this circles back to the types of people that often end up in NM roles – the expert clinical staff, who functioned at an advanced level on the frontline, and maintained high personal and professional standards for themselves in terms of the work that they did and the care that they provided. These qualities do not disappear with the change in role. If anything, they are magnified because with taking an upward step in one's career, the stakes feel higher, the work is more challenging, and it seems that there is more to prove because this is not a job that just anyone can do.

It is important for new NMs to receive performance feedback, so that they feel valued in the work that they are doing and receive validation that they are performing in the role (Brown, Fraser, Wong, Muise, & Cummings, 2013). Receiving performance feedback can positively impact NM job satisfaction, increasing retention and performance within the position (Brown et al., 2013). As a frontline nurse, success in the role seems clearer and easily discernible. If the nurse's patient gets better, or goes home, and the nurse completes the tasks that are required, that nurse has done a good job. When asked about the best way to prepare new NMs for the role, participants thought that more support was needed, such as the provision of a structured orientation similar to what frontline nursing staff receive, ongoing mentorship and peer support, and the identification of resources related to NM specific tasks and duties. Alex summed up the

views of the other participants with her description of the optimal versus actual state of NM preparation:

> *I had a couple of meetings with her [*my manager*] and then I was basically dropped off and told to figure it out. And I wish there was just a bit more support and structure. A nurse is orientated and they do all these classes and they have this many buddy shifts and it's set out, and if they need more, they ask. Whereas, with this, when you're supposed to be running the whole ship, you're just like, "okay, figure it out."*

Frontline nurses are taught and orientated to their work areas to know what is expected; they are taught how to establish a routine, and they are provided with policies, protocols, and standard operating procedures for the work that they are doing. This is not true of the NM role, and as such, it makes sense that those who are new in the role are often left wondering if they are doing what they should be doing, and if they are achieving any of the forward momentum they are working so desperately for, within the infinite, ambiguous, and overwhelming nature of their work.

**Feeling Like an NM Imposter**

Sandberg (2013) talked about "imposter syndrome" and the feelings that many people, women specifically, experience as they find themselves achieving career success. Imposter syndrome describes feeling as though you have snuck into your role, that you do not deserve to be there, and an accompanying fear that you will be found out, that others will see the insecurity that you are feeling. So pervasive and crippling is this fear, that individuals experiencing imposter syndrome are often blind to their own accomplishments and fail to see the

achievements that have brought them to the place where they currently are. Alex described this sensation as she talked about how she felt about herself in the role:

> *You know, I feel like an imposter sometimes. But I really have been around for awhile now, and I'm getting more confident in this . . . Hopefully I get there. It feels good when you're in a job and you just get it . . . You feel like an imposter, but actually everybody feels that way…I bet my nurse clinician that's doing a Rockstar job feels like an imposter sometimes. And my educator who's incredible, she's said as much too.*

Perhaps these feelings of inadequacy come from the speed and magnitude of the career shift that NMs experience. Individuals that have moved from frontline nursing into these roles often find themselves being catapulted from the bedside into the boardroom. People that were wearing scrubs and saving lives can find themselves sitting in offices and around meeting tables the very next pay period. It is often not a gradual move, and a subtle transition as one slowly learns the role and the nuances that being an NM brings, it is a quick flip, and individuals must attempt to acclimatize to their new jobs and the related challenges rapidly.

With this being the case, it is not a surprise that new NMs may feel like they do not belong. In the early days of the role, and given the inconsistent methods of preparation, new NMs have not had the opportunity to learn and master the skills and competencies that would enable them to feel like they knew what they were doing. Added to this is the combined ambiguity of the expectations of others and high expectations of self; when high achieving, clinical experts-turned NMs must process all of these changes, many of which leave them feeling like new nurses again, it is not surprising that they feel like imposters. Sue described feeling as

though she did not know whether she was doing a good job while she was in her role, and the way that her early relationship with her team may have influenced this feeling.

> *At first, they didn't really come to me. They would still always go to [*my boss*]. Then finally, some people would start to come to me, and even the ones that probably thought I couldn't handle the situations . . . I think I kind of expected it because I knew there's a bit of transition for getting that comfort level with new management.*

From this, it is as though Sue's team fed the feeling of the imposter syndrome. She was new, and therefore, she was not ready to fulfill the full obligations of the role. While she did not communicate it as such, Sue's expectation that staff would take time to know and trust her suggested that she may have felt like an imposter, and that she might not yet have fully developed the skills and abilities that she needed. Sue overcame this feeling, however, with the moment of realization coming after she had decided that she would return to her frontline position.

> *You think you're not doing a good job, I guess. And then you realize, ok…The more people were coming to me, and the more open people were being, I kind of realized that they're getting used to me and obviously I'm doing something ok if they're coming to me.*

It was a matter of Sue experiencing a tangible gesture and indication that she was performing adequately in her role for her to begin to overcome the feelings that she did not belong in that role. The receipt of such feedback was necessary to overcome the expectation that staff would not come to her and see her as a viable leader.

## Meeting the Extraordinary Expectations of Oneself

Despite being plagued by feelings of uncertainty regarding their performance, participants were able to appreciate and communicate successes and accomplishments that they had achieved within their roles. They were able to communicate positive moments, and meaningful changes and actions that they were able to ignite within their areas and teams. Undoubtedly, this was related to the high standards that these NMs had set for themselves and held themselves to. NMs reported feeling an obligation to be simultaneously visible, available, and accountable to their teams, with many feeling the need to be present and reachable 24 hours a day (Steege et al., 2017). Participants talked about some of the moments that had challenged them throughout their role transition, and I was in awe of the lengths to which these NMs went to follow through on the work that they were doing and tasks that they felt a sense of ownership over. Shortly after she began her NM role, Alex initiated a formal investigation into the conduct of one of her staff members. The investigation process is one that is somewhat foreign to new NMs and can be a significant source of tension between the NM, the staff member in question, and the nursing union that is involved to represent the staff member. Investigations are a necessary evil of being an NM; they need to be done to ensure that staff are held accountable for their actions, but as a result, they invoke a high level of stress for those that are involved.

An investigation alone is enough to challenge a new NM, but for Alex, this was not the only stressor that she was to endure. Alex had initiated the investigation process and had started the arduous task of preparing for her first investigative meeting, in which she would question her employee about the incident of concern, with representatives from the union and HR present. Several days before this meeting was to occur, Alex's close friend experienced an unexpected

medical emergency, passing away in intensive care. In spite of the tremendous tragedy and grief that enveloped her in those days, she chose to move forward with the investigation, and to conduct the meeting as originally planned. As Alex recalled this occurrence, both the sadness and the frustration that she was felt was palpable.

> *I had some terrible things happen this summer, I had a close friend pass away. So, the investigation was two days after that. So, I came in just for that meeting, but I probably shouldn't have. And I had a* ***huge*** *run-in with the union guy. He cornered me and ripped a strip off me. We were right in the HR office and I started crying right before I had to go into this investigation. I'm not a crier at work, but I had so many personal things going on, so he threw me completely off my game. So, then I went into my first investigation, terribly. Bombed it.*

Despite all that she was up against personally, she insisted on pushing forward with this task. Where others may have considered rescheduling or having someone else complete the meeting in their place, this was not an option for Alex, because this issue was her responsibility, and no matter what, she felt the need to see it through until the end. Perhaps as a frontline nurse, Alex might have felt that she could relieve herself of those professional obligations in the interest of tending to her own needs, however, given the sense of ownership and responsibility that NMs feel related to their role, this did not exist as an option in her mind.

When pushed to these extremes of emotion and stress, there inevitably comes a breaking point. Amy, who I would describe as pragmatic, direct, and level-headed, told me about the moment where she hit her limit, where the extreme lengths that she had willingly been pushing herself to for months came to be too much.

> *I think I don't ask for help soon enough, because I don't ask unless I really need it, because I figure I can figure it out. I did have a moment where I broke down. And these don't happen much because I'm not a crier. But, I think I was in one of my de-briefs with my current manager about two months ago. And I was just very frustrated with the way that this one site of mine was going. It seemed like we'd made all this progress and then it just halted. And we were talking about it and I started off and I was being positive and I explained all the things that were working well. And then I just started crying. I am not a person who cries. So, if I'm doing it, something's not working. Because it was like I'd reached my max, I think. That was when I stopped doing on-call [*duties above and beyond her regular full-time hours*]. And that's made all the difference.*

Amy had taken on these extra, on-call duties willingly, because the sites that she was managing required the additional assistance. However, despite her interest in providing after-hours support, she was not compensated for this time given that it was not a part of her job description, and other managers in her team had not taken on the same responsibilities. While Amy could have chosen to not make herself available after hours, she likely felt that she would pay the price with added workload because these issues would be waiting for her when she returned to her regular work day. Again, I contrast the way that we might view a frontline nurse in a similar situation. If an individual was working countless hours without receiving appropriate and proportionate compensation, there would be consequences for the individual allowing that to happen; it is not something that we would expect a person to do. Furthermore, if a frontline nurse was feeling terribly overwhelmed and overloaded, we would anticipate that they would voice their need for assistance so that appropriate support could be provided. Amy recalled that

when she hit her breaking point, her manager's response was, "*finally!*" As if to suggest that of course, this was too much for one person to handle, and of course, she should be feeling this way. However, because Amy felt an incredible determination to persevere, she was allowed to keep taking on more than anyone reasonably expected her to be able to handle. In spite of this, Amy did not feel like she could say no to the additional duties, regardless of the impact that they had on her personal wellness and life outside of work.

One NM that I spoke with was able to recognize when enough was enough, and when the impact of her personal life meant that she was not able to continue as an NM. Sue shared with me the story of the recent passing of her sister following a battle with illness. She found herself overwhelmed with grief following the loss, and decided that this, in combination with the challenges and tribulations of transitioning into her role as an NM, were more than she was prepared to cope with. Following a great deal of thoughtful deliberation, she chose to return to her previous position as a frontline RN. As she told me about this point in her first year of being an NM, she was overwhelmed with emotion, crying as she recalled the raw and painful moments both of experiencing this loss and coming to the decision that she would not continue as an NM. It was clear to me that Sue had made a brave choice, to do the right thing for herself, and to listen to what her grief was telling her she needed. She talked about when she knew that she could not continue in her NM role, a decision which she came to with a considerable guilt.

> *Mostly it was just because my sister had passed. So again, it comes to looking at the work-life balance, and what I needed for myself. I had a difficult, difficult [*client's] *daughter who I was dealing with, it wasn't even anything that had to with any discussion, I just starting crying on the phone. I was like, "what's wrong?" I've dealt with worse*

> *people, more difficult situations, and I just thought, this where you need to step back. And I think we're really bad for not putting ourselves first. In all of health care. It was a difficult decision because I wanted to do what's right for the team. And I felt like by leaving them that I was putting them out. And feeling like I had let my boss down for making the decision to choose me [*for the NM role*]. There was just so much still to learn, and I thought, right now, I need to step back.*

I was struck that Sue was focussed not on the fact that she had chosen to put herself first, but that she might be letting her team down by doing so. NMs are people, with lives outside of their offices, that deserve the freedom to be human and do the right thing for themselves. Working through the phases of transition takes considerable energy and focus, and to relate back to the ideas of storming and norming (Tuckman, 1965), Sue was not ready to push through this part, and to allow this to become her new normal. This was a choice to focus her energy on her own needs, and to relieve the tension that had been pulling her in so many different directions.

### Work-Life Imbalance

Brown et al. (2013) found that it was important for NMs to be able to limit the hours that they worked and be able to acknowledge when they had done enough. The high expectations that NMs hold themselves to do not just mean that they push themselves professionally, it also impacts their lives outside of work. The NMs that I spoke with struggled with finding a sense of work-life balance within their new roles. All that they had taken on with their career shift meant that it was more difficult to separate work and home, and to find the time for themselves and their families that they may have previously taken for granted. Finding time for exercise, getting adequate rest, vacations, and debriefing with colleagues were noted as being wellness strategies

that NMs should employ to avoid fatigue and burnout (Steege et al., 2017), and yet these were simple tasks that participants had difficulty in achieving. Sarah did not just feel that work-life balance was hard to establish, for her, any sense of this was nonexistent.

> *I don't have any work-life balance. Before I started my masters, I used to go to spin and yoga classes three days a week. Then I started my masters and that dropped dramatically. And then I started this job and now I go like once a month. I find that I get home and it's just, like, feed the kids, tidy up a little bit, try and spend some one on one time with them, put them to bed, and then I may work on some schoolwork or I may just zone out on the couch. And then weekends we try and do family stuff because there's no time now that I work Monday through Friday to do stuff during the week…And then everything kind of falls apart at home.*

Hearing Sarah say this, it was a clear that this was not just a matter of being busy or feeling like she was taking work home, her change in role impacted her entire life. The extent to which this transition permeated her life did not stop at the hospital doors, it followed her home, it impacted all of her time, and changed the entire dynamic of her personal life. It was interesting to consider that moving away from shift work and beginning to work a Monday to Friday job had challenges. Frontline nurses are largely shift workers that get to enjoy the benefit of working off hours, having time off during the week, and often, a higher degree of flexibility to balance the demands of family life. This is likely a consequence that people do not consider before entering into the NM role, because the largely held assumption is that shift work is more difficult than a set, Monday to Friday schedule.

Amy also struggled with work-life balance, but for her, it was related to the unrelenting volume of work that seemed to follow her everywhere that she went. She addressed how hard it was to do something as simple as taking a day off in lieu for all of the extra work that she was doing on a routine basis.

> *I don't feel like I can be off for a whole day. Or when I'm covering weekends, I'm supposed to take a day off somewhere in the week to but make up for the time I work on the weekends, but I can't, so yeah, it's a bit crazy.*

Amy is responsible for managing nurses in the community, so the remote and mobile nature of her work not only keeps her busy, it makes it difficult for her to keep contact with her NM colleagues. She found this challenging in the sense that she was not sure whether everyone was as busy as she was, or whether she was being pushed beyond what was reasonable.

> *If I saw them all the time, and I knew what they were doing, then I'd know if that was normal or not. But I don't see them because we're all over the place…so then I don't totally know if everybody looks like this, or is it just the south [*the area she covered*], or is it just mine, or am I being too involved?*

As Amy spent more time in the role and developed relationships with her NM colleagues in spite of their remote workplaces, she discussed the way that they supported each other through the never-ending workload.

> *I get emails up until 11, 12 o'clock at night, pretty much every evening. So, I could be working all the time, and that's one thing that my care manager buddies will give me a*

> *hard time about too . . . we try to say, we'll work evenings three nights a week. That's kind of our pact to each other.*

Shirey et al. (2010) noted that receiving support from others and being able to enjoy quality downtime resulted in decreased levels of stress for NMs. For Amy, there was no clear demarcation between the office and her home, and at times, it was up to her family to push her to disconnect from her NM role and enjoy the downtime that she required. She acknowledged that without her husband telling her to work less while at home, she would probably work all the time.

> *I was, and still am tired. And that carries over to your home life, right? My husband noticed, he's like, "you're working too much, you're working in the evenings too many times, you're working in the weekends, and you guys don't get paid enough for how much you're working" . . . I'm glad that I have a husband that tries to cut me off, because I think I'd probably work even more . . . I get guilt tripped heavily if I do work at home. So, if I come home and my head's all up in work stuff, they're just like, "you're not paying attention."*

The nature of the NM role makes it difficult to disconnect and achieve a sense of work-life balance. The work that piles up and the problems that are not resolved wait for NMs when they go home at the end of the day. Disconnecting means that they are not clearing these tasks from their to-do lists, and that there is the potential that they will be returning to a larger mountain of work or a more significant problem.

## Stuck in the Middle

A question that is often part of the job interview for potential frontline staff asks them to demonstrate their ability to juggle multiple, competing clinical priorities. The expectation of being able to find this balance and prioritize effectively extends to the NM role and is an ability that is not left behind on the frontlines. Where the ability to manage these priorities for NMs diverges is that demands do not only come from one place and are not limited to the clinical arena. No longer is it enough to ensure that good care is provided, good care must be provided in a way that fits the budget, meets organizational values, and is done alongside numerous other projects and accountabilities that are delegated from the NMs' senior leaders. Furthermore, the way in which NMs decide to manage these priorities is likely influenced by their frontline nursing prejudices. NMs have often spent a large portion of their career working in a frontline capacity, and for new NMs in particular, that context lives fresh in their minds. Participants expressed feeling the tension of trying to meet the needs and expectations of patients and staff, while simultaneously being mindful of the priorities that were coming down from leaders above them, and being aware of the resource limitations of the current system. Sarah discussed encountering this tension:

> *There's always initiatives going on, and people's directives. And everyone's important, so then trying to balance everyone's initiatives, what people want for learning and also what they actually have to learn. All within your worked hours . . . I find it overwhelming for how many things we need to cover. That alone. And then like, how much money do you put into education and training and stuff like that? What's ok?*

When being pulled in so many different directions, it is difficult to know where to focus one's energy, and how to make the most meaningful impact possible. Sarah expressed the difficulty that she experienced in knowing where to focus her energies when it came to the pressures from above.

In situations where NMs seek to make positive changes and improvements, it is not as simple as deciding to do something and then moving it forward. As Sarah found, it is a delicate art, and a skilled dance, of bringing ideas to fruition.

> *It just depends on what the topic at the time is, and then learning how to read people and when is an appropriate time to talk about something or ask something, and when I might want to table it for another day . . . you have to read people and know what they're feeling and also know all your resources and it's really hard to find out what resources are out there.*

She spoke about an idea that she brought forward to her boss, suggesting a low-cost way to provide snacks and nourishment for patients and their families. This idea was supported by her frontline staff, seemed simple, and was aligned with organizational priorities in support of patient and family centered care. It would seem that this idea was a hit, however, when Sarah asked her boss, it was shot down immediately; she had read her boss incorrectly and chosen the wrong moment. It was not until it came up again, this time in the presence of a more senior leader that she was given permission to move forwards.

NMs are left feeling that, "I can't win…you've got all the feedback from the nursing staff plus all the pressures from above you and it's not an easy job." The feeling that NMs experience of being stuck between the pressures above and the pressures below seem to be synonymous

with the notions of impossible tasks and leaky faucets. In much the same way that NMs that I spoke with expressed never-ending issues requiring attention, and never being able to do it all, the same acceptance is required of these pressures. It may not be possible to please everyone, therefore, what NMs must do instead is negotiate these challenges as well as they possibly can, accepting that it is never going to be perfect. One NM that I spoke with reflected on the advice that she wished she had received, and how she may have mitigated the angst that can accompany being pulled in many directions: "it's a lot to take on and no one expects you to be perfect. Everyone wants to do a good job . . . but sometimes it's not an easy path to get there."

## Concluding Thoughts

At best, I think that NMs experience challenges in establishing a healthy work-life balance throughout their role transitions, but at the worst, some likely experience a complete absence of this equilibrium. NMs that I spoke with held themselves to extremely high standards and were reluctant to highlight the good work that they had done in their role. This was in part due to the lack of clear expectations and evaluation systems, and the way that they felt like they were plunked into the thick of their role and were expected to figure it out. While this level of autonomy was likely awarded to them based upon their demonstrated competence, it did not always instill a sense of self-confidence, or assurance that the work that they were doing and the results that they were achieving were what they should be striving for. Being that strong nurses are often chosen to be NMs based on their clinical excellence, it makes sense that these individuals will bring with them the same personal expectations of perfection, success, and achievement. What they are not prepared for, however, is the fact that it may take time for them to reach the same level of proficiency that they possessed while at the bedside, and that it is

important for them to maintain realistic expectations for themselves in the meantime. Additionally, new NMs must learn to adapt from not only managing competing priorities in one realm, but must learn how to handle being pulled in multiple directions. This balancing act was recognized time and time again by participants that I spoke with, whether they "had a lot of balls in the air," were "walking a tight rope," or were trying to "do more with less."

# Chapter 7: Conclusion

The conversations that I had with participants, and the interpretations that arose as I reviewed and reflected upon those dialogues shaped a new understanding of the experience of role transition. In speaking with NMs who were at various points along the continuum of transition, I was able to relate and identify with thoughts and feelings that I too had encountered in my personal journey. Despite being able to relate, and despite at times feeling so drawn into these conversations that I began to wonder whether I was the sixth participant, no one had the exact same experience. While certain challenges, triumphs, and learnings were shared, there were no two people that I could definitively say had experiences that were entirely alike. What this suggests to me is that given the complexity and importance of the NM role, there is nothing simple or straightforward about the path that one takes to assume this role. The previous chapters detailed the aspects of the experience of role transition that revealed themselves to me, that sought interpretation and exploration, in order to come to a place of new understanding about the experience. I considered what these new understandings might mean for NMs, both current and aspiring, and what recommendations could be gleaned and put forward to support new NMs through this overwhelming, exciting, and often, tumultuous time.

## Implications for Current NMs

The participants that I spoke to were all at different points in their journey through role transition, from a mere five months into the role, to those that were nearing two years as an NM and ambling towards a place of contentment and stability. Something that is important for current NMs to take away from these interpretations and understandings is that the journey through role transition is neither linear nor predictable. While there were definite ties to Benner's novice to expert theory (1984) inherent in the experience of role transition, the stages

of proficiency looked different for each individual that experienced them. New NMs do not spend the same amount of time in each stage of proficiency; some advance to expert more quickly than others, and some may even choose to step away from this pathway all together. Where one NM is at a year into their journey is likely not where someone else will find themselves at that same time point. It is important for current NMs to be able to acknowledge this as being normal, and not a sign of deficiency or not being a fit for the role. It is important that NMs, both new and experienced, accept the level of chaos and disarray that often accompanies the job that they do. In hearing the expectations that NMs held themselves to, and the need to get it all done, and figure it all out, it seemed that they were striving for a level of perfection that was not necessarily attainable in the role that they had taken on.

New NMs often feel like imposters in their roles, waiting to be exposed as someone not worthy of their titles, and like they do not deserve to be there (Sandberg, 2013). In part, this is an aspect of human nature, and likely related to the speed with which one's career can change, and the accompanying lack of preparation. However, it is hard for new NMs to shake the feeling that they are not good enough to be there when they are not able to see that everyone else is struggling alongside them. That was an important realization for me to make, and ultimately what led me to want to take on this research topic. Prior to stumbling into a circumstance where I was lucky enough to find someone that spoke openly about their struggles, I felt alone. I suspect that many NMs share these feelings, because we wear our struggles quietly, in an effort to protect ourselves from exposure, to not be seen as the imposters we feel like we are. I have often heard the expression, of feeling like a duck in a pond – while the duck appears to be calmly wading, what is not seen is the duck's legs, frantically treading water below the surface. Although no two NMs will have had the same experience in arriving to their roles, I do believe

that every NMs has encountered challenges, and has spent at least some time desperately treading water and trying to stay afloat.

**Negotiating New Professional Identities**

As the literature had suggested, it is important for NMs to be able to maintain a line of sight to the frontlines, however, I argue that this is not only from a standpoint of ensuring job satisfaction and a purpose for the work that they are doing; this is a means of maintaining a connection to their nursing identity. I think it is easy to focus on the management side of the NM title – the tasks that an NM does in a day to maintain the operations of their area, to support staff, and to ensure that patient care is delivered in a way that is safe and effective can easily supersede the aspects of the role that allow the NM to feel like they are still a nurse. While I acknowledge that the NM role requires a shift in this identity, I think it takes time for the NM to strike a new balance with their nursing identity, and to determine how they can make it fit with their new role.

Negotiating this identity shift is a representation of the fusion of horizons, of finding new meaning through integrating our history and previous contexts with our experiences at present. It is a blending of one's nursing identity, beliefs, and prejudices with the responsibilities of a new and different role and realizing that our past and history will always influence our current place (Gadamer, 1989). I do not believe that there is a standard way that this can be done, in much the same way that there is not one truth to be found in hermeneutics; each individual must determine what aspects of their personal and professional identity will carry through to their new role, and what new traits the transition will breed within them. Individuals must determine their own meaning and understanding of the role that they are undertaking and their new normal, as an NM.

**The NM Relationship Shift**

The professional support system for the NM undergoes a drastic change with the move from frontline nursing to formal leadership. Where there were once handfuls of colleagues to talk to, laugh with, and survive the workday alongside, the NM finds themselves in a much more limited circle. NM colleagues and peers are smaller in number, and are also spread out, working in different offices, on different floors, and sometimes, in different buildings. In adjusting to new relationships, previous relationships must often undergo change. New relationships that are revealed with the role may mean there is a need to let go of, or change, previous relationships. Aletheia is at play, as the new NM unconceals new relationships and connections within their role, they must conceal those that will not survive the transition, or that must change shape in order to continue to exist.

It is important that NMs establish support networks with their colleagues, so that they have others to relate to, to share their struggles with, and to normalize the challenges that they feel they are alone in. Several of the participants that I spoke with described our conversation as feeling like therapy, you could see the relief as they let it all out, possibly, for the first time, to someone that understood what they were going through. It should not be this way; NMs should have an outlet to work through these frustrations and experiences, to be able to bounce ideas off others, and to be reassured by someone else that has been there. Establishing these relationships not only leads to a sense of contentment and belonging, it helps to form coaching and mentoring relationships, which are a vital part of the way that new NMs learn their role, network within their organizations, and develop professionally (DeCampli, et al., 2010; Weinstock, 2011). It is not only incumbent of new NMs to seek these relationships out, it is also the responsibility of

experienced and settled NMs to reach out to those that are new in the role and may not have the confidence or the awareness to establish these relationships themselves.

**Managing Expectations**

Expectations are a huge part of the NM role, motivating performance, provoking action and effort, and influencing the self-perceptions of both new and established NMs. Perhaps it is human nature, or maybe it is characteristic of the types of high-performing individuals that find themselves in NM role, to set expectations and goals for one's self that are lofty, and that exceed what is realistic or reasonable in terms of achievement. The NMs that I spoke with embodied this completely; they cared so much about doing well in their roles, helping their teams, and demonstrating proficiency that they did things that no one would reasonably expect of them. They worked through their hardest days, they dealt with overwhelming emotions creeping in from their personal lives, and they gave up a sense of work-life balance to be fully committed and present for their NM roles. It is important that NMs take a step back and assess where these expectations are coming from. What an NM is expecting of themselves is not necessarily what their team or their leaders are expecting. This does not mean that NMs should not seek to excel, but should rather find a balance in terms of where they set their expectations, and should seek a marker that allows them to perform, yet maintain the delicate work-life balance that so many struggle with.

NMs must make themselves a priority, and not find themselves lost in the quickly moving current of this role transition. Many participants that I spoke with had let this priority slip away but recognized the importance of things that did not have to do with their NM role, such as exercise, family time, and meaningful social relationships and activities. In order to establish a reasonable sense of expectation, NMs must have these conversations with their

leaders. Through having a dialogue about performance and expectations, the ambiguity of what they are expected to do is diminished, and rather than killing themselves to meet an impossible standard, they can find satisfaction in achieving what they know they need to achieve. Establishing an open channel of communication regarding expectations also provides the opportunity for the NM to receive feedback about their performance, and acknowledgment for the things that they are doing well. Often NMs are not given the positive reinforcement for the little things that they are doing right because it is easy to forget that those working at a high-level grapple with insecurities and uncertainty.

## Implications for Aspiring NMs

For those considering heading down the path of formal leadership within the NM role, the above implications for current NMs provide guidance in terms of how to mitigate some of the more challenging aspects of the role transition. Moving towards the NM role with realistic expectations about what it will be like to make a drastic career change, and to move into an area of nursing that many have not had any previous exposure to at the frontline may allow for a less jarring experience. For those that have the foresight to plan for this role transition, and to see it as a part of their future, they should be prepared to ask for the things that they will need to weather the challenges of this practice change. Knowing the ways that a person might struggle, and how it might feel to leave frontline nursing practice allows the opportunity to prepare to ask the right questions, to seek out the appropriate supports, and to avoid despair in the early days in the role. Rather than living with the feeling of never being able to fix the leaky faucet, feeling disconnected, and feeling that they are the only ones to have ever struggled this way in the role, aspiring NMs may carry these understandings with them, and feel prepared for what lies ahead as they embark on the next stage of their nursing career journey.

## Recommendations

The new understandings that are shaped through interpretation serve to do more than deepen what we know about our topic, they help to guide us towards what it is that we are to do with what has been revealed to us (Moules, McCaffrey, et al., 2015). Hermeneutic research provides instrumental, symbolic, and conceptual utility that guides us in the application of our findings (Moules, McCaffrey, et al., 2015). The recommendations that I have put forth based upon my interpretations addresses instrumental utility in providing specific suggestions in how to best support and prepare new and aspiring NMs. A significant contributor to the challenges in role transition that were encountered by participants was the inconsistent way in which they were prepared for the role. Some received a brief introduction to their role, some felt that they were to figure it out on their own, and some received employer provided training or courses to support their development. The comparison was made to the prescriptive and methodical way that new nurses are prepared for their role. New nurses complete classroom time, are partnered with experienced staff members to shadow and work under supervision, and are required to complete checklists of skills and competencies before they are permitted to practice independently and without the oversight of a mentor or educator.

With a role as complex and imperative as that of the NM, it is a staggering thought and realization that the same level of rigor is not applied to the way that we train and prepare the individuals that are ultimately responsible to maintain the operations of functional units of the health care system. The NMs that I spoke with clearly articulated that a more structured orientation and training process would have eased some of the tension and unease that they experienced in trying to find their footing in the role. If health care organizations were to invest in the early days of a new NMs career, they would create a network of stronger leaders that are

confident and effective earlier in their leadership careers. For some, the work of learning the role on their own feels insurmountable, like it did for Sue, who felt unable to continue as an NM. For others, even when leaving the role was not considered in response to the struggle, such an investment might have made their transition less painful, might have resulted in fewer moments of feeling like a failure, and may have alleviated the unrelenting feeling of just trying to survive. Not only would a smoother transition into the NM role result in improved job satisfaction, positive outcomes would permeate outwards; frontline nursing staff would be better supported in the work that they were doing, further resulting in improved quality outcomes and increased patient satisfaction.

From a standpoint of conceptual and symbolic utility, my interpretations demonstrate that we must consider the challenging nature of role transitions and understand that becoming an NM is more than taking a new job title. It is a shift in identity, an upheaval in relationships, and a relentless balancing act. In order to change how new NMs are prepared and supported, it must first be accepted that it is necessary to do so and allow this persuasion to change behavior and ways of thinking about role transition (Moules, McCaffrey, et al., 2015). Comprehensive preparation for new NMs should not only consider the need for theoretical knowledge about the role and instructions on how to perform tasks, it must also encompass the social and emotional needs that accompany this transition. It would be helpful for organizations to establish and support formalized mentorship and coaching programs for new NMs. Coaching and mentoring provides the opportunity for new NMs to connect with others over the challenges that they are encountering, talk about their experiences, and seek out advice and feedback from people that have expertise within the role. So much of the work that NMs do involves figuring out how to solve a problem that they have never encountered before, and a strategy that is employed in

doing so is getting advice from others, and talking through the dilemma. Establishing mentoring and coaching relationships provides NMs with a forum to do just that, and a safe place to not know the answer and get advice. Making regular connections with others might also help new NMs to know where it is reasonable to set their personal expectations, and to be aware of what others in similar roles and positions are doing and achieving.

Finally, it would be of considerable benefit for organizations to offer greater transparency regarding the NM role. So much of the role is unseen and unknown by frontline staff. It is not clear until you step into the role what your job is, and even once in the role, it can be difficult for an NM to clearly articulate in a way that is meaningful to others what exactly it is that they do. I think that if an organization were able to clearly and accurately explain what an NM does, what is expected from individuals in the role, and how the work of the NM is carried out and evaluated, there would be benefits to both current and prospective NMs. Through providing this measure of clarity, NMs in the role may better be able to understand what is expected of them, and work towards these standards, rather than the impossibly high standards that they self-determine and impose upon themselves. It may become clearer to NMs when they are doing a good job and provide the encouragement that can be so desperately needed in the challenging moments that are found within the role. Prospective NMs would have the opportunity to possess a better sense of what the role is before they are fully immersed in it. This would allow the opportunity not only for mental preparation, but for interested and motivated nurses to seek out the skills and knowledge that they will need prior to taking on the role. Furthermore, increased transparency regarding the role may encourage RNs that had not previously considered a career in leadership to give this idea thought and consideration, providing the potential to supply the future leadership pipeline.

## Final Thoughts

The interpretations and understandings that I established throughout the process of conducting this research do not represent a singular, objective truth about the experience of role transition. Rather, these interpretations express the understandings that were revealed to me as I explored the complexities of this topic and are reflective of the context within which I examined role transitions (Moules, Field, et al., 2014; Zimmerman, 2015). I acknowledge that while the learnings that emerged were significant and contributed to deepening my own understanding of the topic, they may not represent the experience for every person, and could lend to a completely different interpretation when looked at in a different setting or context. I also acknowledge the limitations of my study – the NMs that I spoke with were all female, and worked for the same healthcare organization within the same geographic area. Based upon this, my findings may not be considered generalizable to other contexts. In spite of this, the truth that hermeneutics generates is not based on generalizability, but rather on transferability (Moules, McCaffrey, et al., 2015). Transferability suggests that the findings of a study can hold meaning and applicability, even when considered in different contexts (Moules, McCaffrey, et al., 2015). Although my findings and interpretations may not represent the truth for every NM that experiences role transition, I ensured thoughtful consideration and awareness of other points of view, and presented them in a way that was coherent and attended to the research topic in a way that furthered understanding, and retained the potential for further inquiry into the topic (Moules, McCaffrey, et al., 2015).

These understandings represent the answers that I was able to derive to the questions that the topic asked me – they are the result of deep reflection and engagement with my data, and with the conversations that I had with participants. Through these dialogues, I was taken down

paths of understanding and interpretation that I could not have predicted prior to initiating my research. I can acknowledge that while I thought the conversations that I had would tell me that the experience of moving from frontline nursing to NM practice was challenging, I could not have anticipated the ways that this research has changed my understanding of the experience. This was a representation of me being aware of how my own prejudices were present in my research and interpretations. I was able to recognize the ways in which what I was learning related to my own experience, yet was open to, and appreciative of, the ways in which my perspective was shifting in response to new understanding.

My hope is that through reading this, NMs that are in the thick of role transition, or are experiencing the moments of extreme doubt and uncertainty feel comforted to know that becoming an NM is not easy. The people that make it look this way are the same people that struggled with many of the same challenges, that learned the same hard lessons, but ultimately came out on the other end of their role transition. For those that have settled into their role but look back at their early days and grimace about where they came from, I hope that they too recognize this as part of the journey and take the opportunity to reach out and support someone else that is where they once were. Finally, for those that are considering advancing their career, I hope that they feel encouraged to do so through reading this work. The NMs that I spoke with presented a candid, distinctly human, and unintentionally modest and humble picture of the challenges, triumphs, and learnings that they have encountered, all while retaining a connection to their professional and personal identity as nurses. My research is not meant to end the conversation, but rather to lead to further questions, and further dialogue. Through this infinite widening of inquiry and interpretation, we may continue to always deepen our understanding of

the experience of transition into a role that is as misunderstood and underrated as it is complex and integral to the functioning of our health care systems.

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# Appendix

Interview Guide

1. Can you tell me about your career thus far and your journey to a nurse manager role? What was it like to transition from frontline nursing to management?
2. Is there anything about the experience that stands out to you in particular? Any aspects that were challenging? Invigorating?
3. What has been a significant/surprising/helpful learning from the experience? If you could go back and give yourself one piece of advice when you were new in your role based on what you know now, what would it be?
4. Is there anything we didn't talk about or anything thing that I didn't ask you that you would like to address?
5. Any questions for me?