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Lamp light on leadership: clinical leadership and Florence Nightingale

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Aims The purpose of the present study was to use the example of Florence Nightingales' nursing experience to highlight the differences between nursing leadership and clinical leadership with a focus on Miss Nightingales' clinical leadership attributes.

Background 2010 marks the centenary of the death of Florence Nightingale. As this significant date approaches this paper reflects on her contribution to nursing in relation to more recent insights into clinical leadership.

Evaluation Literature has been used to explore issues related to nursing leadership, clinical leadership and the life and characteristics of Florence Nightingale.

Key issues There are a few parts of Florence's character which fit the profile of a clinical leader. However, Miss Nightingale was not a clinical leader she was a powerful and successful role model for the academic, political and managerial domains of nursing.

Conclusion There are other ways to lead and other types of leaders and leadership that nursing and the health service needs to foster, discover and recognize.

Implications for nursing management Clinical leaders should be celebrated and recognized in their own right. Both clinical leaders and nursing leaders are important and need to work collaboratively to enhance patient care and to positively enhance the profession of nursing.

Keywords: clinical leadership, congruent leadership, Florence Nightingale, nursing leadership

Introduction

The delivery and organization of nursing has for many years been influenced by the writings and example of one of nursing's greatest leaders: Florence Nightingale. 2010 marks the centenary of the death of Florence Nightingale and therefore the present study considers Miss Nightingales' nursing practices against more

recent perspectives of clinical leadership. Using documentation from a number of contemporary publications and sources, Miss Nightingales' care practices, approach to nursing care and subsequent acclaim as the first lady of nursing will be assessed against a set of clinical leadership criteria.

The question of whether Florence Nightingale was considered to be a clinical leader is addressed at the

beginning of each clinical leadership programme run at Curtin University. When asking the participants about their insights of notable clinical nurse leaders, course participants invariably respond with cries of 'Florence Nightingale'. However, the appropriateness of her status as a clinical nurse leader may be called in to question. Course participants (and possibly some readers) are initially horrified at the assertion that Florence may not have been an effective clinical leader. However, when discussing nursing leadership and clinical leadership it is most important to be clear about this distinction. Because it very much influences not just who we see as appropriate leadership role models, but how we understand the significant place of clinical leaders in shaping the delivery of clinical care and quality in the health service. The present study challenges the view that Florence Nightingale was an effective clinical leader. It identifies distinctions between nursing leadership and clinical leadership and highlights the core domains of clinical leadership. The study goes on to describe aspects of Florence's nursing practice against the core characteristics of clinical leadership.

Nursing leadership

Nursing leadership has been written about and discussed for some time and more recently a plethora of leadership courses and initiatives are evident in the health care arena. Leadership with its focus on creativity, change, developing leaders at all levels and better approaches to care has become a significant aspect of health practitioner activity (Frankel 2008). This interest has been supported by a raft of research and literature about leadership theories and concepts. However, the focus of leadership development in recent years has been on what Antrobus and Kitson (1999) call the academic, political and management domains. A review of recent nursing and health service literature supports many studies or articles that have focused on nursing leaders who hold senior posts within organizations, nursing divisions, wards and/or departments (Rafferty 1993, Antrobus & Kitson 1999, McKeown & Thompson 1999, Kitson 2001, Beech 2002, Firth 2002, Jasper 2002, Faugire & Woolnough 2003; Frankel 2008).

Because 'nursing leadership' and 'nursing management' are commonly used as interchangeable concepts, much of the literature related to nursing leadership was developed to support nurses in management positions or with management responsibilities. This has meant that literature and research to support one concept (e.g. nursing management) has been accepted as transferable

when seeking insights or understanding of clinical leadership. Clinical leadership is often mentioned, but it is rarely the subject of research because of its low status when compared with the academic, political and management domains (Antrobus & Kitson 1999). For this reason, the uniqueness of clinical leadership has remained largely unrecognized and under-valued (Stanley 2006a–c, 2008, Watson 2008). Research specifically focusing on clinical leadership has also been sparse. The term 'clinical leadership' is commonly used interchangeably and inappropriately or alongside the terms 'nursing management' or 'nursing leadership' (Lett 2002, Stanley 2008, Watson 2008).

However, it is argued that this is not the case and clinical leadership and management are clearly different concepts (Stanley 2006a, 2008, Watson 2008). If nurses are to understand and apply clinical leadership principles, more needs to be done to outline what clinical nurse leadership is and frame it so that nurses engaged in clinical practice roles can recognize it in themselves and their colleagues, as they work towards developing their skills as clinical nurse leaders.

Nursing leadership is clearly based on a relationship with management and with nurses who may be a step or more removed from clinical nursing functions or who may operate in a broader context at an operational or systems level.

Clinical leadership

Clinical leadership is a relatively recent term. Millward and Bryan (2005, p. xv), in their position statement about clinical leadership in health care, define clinical leadership as being 'about facilitating evidence-based practice and improved patient outcomes through local care'. Harper (1995) followed the same line when exploring clinical leadership from a theoretical perspective describing a clinical leader as a clinical expert in an area of specialist practice and who uses interpersonal skills to facilitate quality care. The links with quality are present in both views, but Harper has introduced the new idea that clinical leadership needs to be linked to the function of clinically based practitioners. Others who have considered clinical leadership agree that clinical leadership sits within the domain of clinically placed practitioners (Rocchiccioli & Tilbury 1998, Cook 2001, Lett 2002, Stanley 2006b–d). This perspective is significant. It brings into sharp focus the idea that nursing leadership (and people who may be seen as nursing leaders) and clinical leadership (and those who may be recognized as clinical leaders) may be very different people operating from very different

positions with different drivers, values, aims and objectives.

Lett (2002) sees a clinical leader as an expert nurse and Cook (2001), after a limited research study, concluded that the clinical leader was most likely to be 'a nurse directly involved in providing clinical care' (2001, p. 39). Stanley 2006a–c, 2008 concluded that a clinical leader is a clinical expert in their field, and who because they are approachable and open, effective communicators, visible in practice, positive clinical role models, empowered decision makers, clinically competent and clinically knowledgeable and significantly, displaying their values and beliefs through their actions are most likely to be seen as clinical leaders. This led to the discovery of the theory of 'Congruent Leadership', which encapsulated these characteristics (Stanley 2006a–c, 2008).

If nursing leaders and clinical nurse leaders can be assumed to have different roles and offer different functions, perhaps Florence Nightingale is not the most appropriate role model or example of a clinical leader.

Was Florence Nightingale a clinical leader?

In order to determine if Florence Nightingale was a clinical leader and could be an appropriate role model, a comparison is offered about what is known of her life and works in relation to the following characteristics of a clinical leader.

Approachable and open

There is considerable evidence that Florence was notoriously difficult to get on with, or even approach. An anonymous St John's nurse during the Crimean conflict mentions being treated with the 'greatest disrespect and unkindness by Miss Nightingale' (Bostridge 2008, p. 232). Another, Sister Joseph Croke, describes Florence as 'sweet amiable, gentle when she is merely doing the lady...but when she wants to domineer she has a way of putting completely aside all her womanish qualities' (Bostridge 2008, p. 232). A great friend of Florence in her middle and later years Benjamin Jowett came to know her quite well through correspondence and visitations and he once wrote that, 'reproving Florence was like pouring cold water on a red hot iron, and produces a terrible hissing' (Bostridge 2008, p. 392). Even her family were kept at arms length on her return from the Crimean War and Miss Nightingale 'employed' her Aunt Mai and Arthur Clough in a type of secretarial role, with the primary aim of restricting visitors and moderating meetings and appointments. Much of this

behaviour has been attributed to her poor health and a reluctance to seek publicity, but even before she became infirmed Florence was not regarded as an easy person to get on with. Famously her sister, Parthenope, described Florence as, 'a shocking nurse' with 'little or none of what is called charity' (Brighton 2004, p. 308).

During her Crimean adventures she frequently clashed with many people, those who disagreed with or opposed her (such as the Army Purveyor and Dr Hall the Chief Medical Officer in the Crimean area) and even people who came to support and assist her. One such example relates to her interaction with her friend Mary Stanley. Mary had been involved in supporting the establishment of the Scutari expedition and had remained in England with the Herberts (Sir Sydney Herbert Minister for War and his wife Elizabeth) and Parthenope to oversee further nurse recruitment. Mary was sent to Scutari with the second party of nurses in December 1854, and when they arrived Florence wrote to Mary asking, 'Dearest...will you come and see me?' At the meeting the next day, Florence formally resigned as the Superintendent of the Female Nursing Establishment of the English General Hospitals in Turkey at Scutari insisting that Mary take her place. Her aim was not to resign at all, but this had the effect of upsetting and distressing Mary, who Florence perceived as a threat and imposter on her glorious mission (Bostridge 2008). Florence had felt betrayed by Mary and turned on her friend with venom that carried as far as refusing to accept a 'jewel' in honour for services in the Crimean from Queen Victoria, if Mary Stanley was offered one too (Bostridge 2008). Subsequently, Mary Stanley never received any official acknowledgement from the Queen for her part in the recruitment of nurses for Turkey or for the care of soldiers in the Crimea. Only Florence's part in the Scutari adventure was officially or publically recognized. Mary was reduced to tears at the meeting and sent with some of the newly arrived Nuns to another hospital at Koulali. The Nuns sent with Mary were also to be at the receiving end of Florence's temper as Florence clashed with the leader of their order, Sister Bridgeman, who Florence called, 'Mother or Reverend Brickbat'. In return, Florence was known by the nuns as the 'Goddess of Humbug', reinforcing an impression that Florence was not an easy person to approach or feel you could be open with.

Effective communicator

In terms of communication two perspectives can be offered. First in terms of her written communication Florence was a master. Her writings and correspondence

have survived mostly intact offering a wonderful insight into her education, the power of her intellect and depth of her interests. She was able to exercise considerable influence by writing to relevant parties and using social networks to direct political and national issues. As a Victorian woman she really was in an extraordinary position of power. Although ironically, she occasionally wrote anonymously or with a pseudonym so that her name and position as a woman did not detract from the potential impact of her views.

Her writing had a significant influence on hospital construction (Notes on Hospitals), army medical reform with a number of essays and publications, nursing (Notes on Nursing) and sanitary conditions in India. As a written communicator, Florence was both persuasive and prolific dealing powerfully with topics in a range of areas. Her influence on the sanitary conditions in India is most remarkable as she never visited the subcontinent and was thought (at one stage) to have better connections in India than even the British foreign office.

In terms of her verbal communication Florence was also effective. She spoke softly and directly, and as with her writing, could be quite sarcastic and cutting. Florence was not typical of Victorian ladies, in that she made a point of speaking her mind and did not suffer fools gladly. In a letter to his wife, a member of the Hospital's commission sent to the Crimean described Florence as having 'all the softness and gentleness of her sex, all the clear-headedness of the mathematician and a capital head for...administration and a boldness for action that quails before no obstacle' (Bostridge 2008, p. 230).

Visible in practice

Miss Nightingale was posted to the Crimea as the Superintendent of Female Nursing services, not as a clinician. In fact, her pre-Crimean 'nursing' work was principally as the Superintendent of the Establishment for Gentlewomen in London. She accepted the post in April 1853, but did not take up her administrative function until later in the year and resigned in August 1854, after just over 1 year in this role. Therefore, apart from 4 months nursing instruction at Kaiserwerth, in Germany in 1851 and 3 months with the Sisters of Charity in France in 1853, Florence had very limited clinical exposure to draw upon. In her nursing instruction she had taken part in what might be considered traditional nursing work, caring for postoperative patients and people suffering with disease and illness, but there was none of this type of work to be had during her superintendant roles.

In a letter to Sir Sydney Herbert (Minister for War and friend while Florence was at Scutari) dated 1853, Florence describes her role at the barracks hospital as, 'I am really cook, house-keeper, scavenger...washer-woman, general dealer and store keeper' (Bostridge 2008, p. 229). There is no mention of nurse. Significantly most of Florence's initial time in the Crimea was spent in the distribution of rations and supplies provided via *The Times* Crimean fund set up to support her work, or in addressing disputes with the Army Purveying officers.

Indeed, the nurses brought out to the Crimean found the restrictions on their own practice frustrating. Most were not permitted to undertake any 'real nursing work' (Bostridge 2008) and Florence insisted that nurses were not to speak with medical officers, to speak only soothingly to the patients and to avoid talking with them unnecessarily. They undertook no night nursing (removing of bed pans or urinals) and did 'only that branch of work which came within a woman's province', namely washing, sewing and cooking. In effect they undertook the work of domestic servants. As Florence was from an upper-middle class home she never engaged in even these duties and designed her superintendant duties to be in keeping with the mistress-servant relationship common to Victorian households. Most of the nursing work therefore was done by male orderlies (Grint 2000, Bostridge 2008).

In her later career, Miss Nightingale was no more visible in a clinical role. After her return from the Crimea she lived a reclusive life, shunning publicity and being often too infirm to attend official functions at work or career-related engagements. She was involved with the establishment of nurse education at St Thomas Hospital and wrote widely on sanitation matters and improvements for hospital design and the health of poor people in England and in India. She also wrote about nursing principles, but never again practiced as a nurse or as a nursing superintendant. Florence returned from her experiences in the Crimea convinced she had failed. Returning to England under an assumed name (Miss Smith, her mothers' maiden name) she felt she had let the 'men' down: 'Oh my poor men who have endured so patiently. I feel I have been such a bad mother to you, to come home and leave you lying in your Crimean graves' (Bostridge 2008, p. 298). She had indeed let them down. The death rate at Scutari was higher than any of the other hospitals (Grint 2000, Bostridge 2008) and while she wanted to put this fact in the official Government report Sir Sydney Herbert had the figures removed so that it was decades before the truth of Scutari was released. By then Florence's iconic position

was unassailable. Florence was visible at Scutari in the hospital and about the wards, she was much loved and admired for being in the Crimea by the soldiers in the hospitals; however, she did little or none of what might be considered clinical nursing.

Positive clinical role model

If as stated, Florence was not visible in a clinical role she could not, therefore, have been a positive clinical role model. Miss Nightingale was visible on the wards of Scutari hospital and particularly so each evening, but this was more a function of discouraging or catching nurses from engaging in sexual activity with soldiers than a function of offering support or nursing care. Miss Nightingale was of the view that an, 'unoccupied nurse will inevitably fall into some kind of mischief, if not directly of a sexual nature, then stemming from the usual problems associated with excessive consumption of alcohol' (Bostridge 2008, p. 234). The nurses at Scutari did no night work and had to be off the wards by 8.30 pm. It was, therefore, during the evenings and at night that the 'unoccupied nurse' was likely to be seeking male company or drink. In some quarters the ordinary nurses recruited for the Crimean War were known as 'the New-Matrimony-At-Any-Price Association' (Kerr 1997). Again, supporting the perception that Miss Nightingale's nocturnal ward rounds were more to do with catching wayward nurses than a focus upon care activities. The point is that she could only be a positive clinical role model if she was actually doing some nursing and the reality is as outlined above, that as Superintendent of Female Nurses, Florence did none. Indeed after a short time at Scutari according to her Aunt Mai (who had joined her at Scutari to help with the hospital administration) 'Florence had ceased to do any nursing beyond her nightly rounds among the patients' (Bostridge 2008).

On her return to England, Florence was too ill to work in a clinical capacity. In fact she contracted brucellosis in Turkey a condition that was to blight her health for the rest of her life (Bostridge 2008). While she offered great encouragement and support to an army of 'probationer nurses' over the rest of the 19th century, she did so by having them visit her at her London address or county estate. None were to see her in a clinical capacity.

Empowered decision maker

Clinical leaders may be the empowered few who have managed to break the shackles of oppressive behaviour to forge new paths and lead clinical care to greater

quality. There can be little doubt that Florence Nightingale was an empowered decision maker. As a Victorian woman she forged new paths and lived as a role model, demonstrating opportunities for women seeking to embrace independent lives. In terms of clinical practice though there are contrary examples to offer. In the Crimea, it was reported to Lord Raglan (the British commanding officer) that she, 'seemed to delight in witnessing surgical operations with her arms folded' (Bostridge 2008, p. 228) and that Assistant-Surgeon, Alexander Struthers, was kept waiting with a man on the operating table for 15 minutes until Florence could be found as she insisted on viewing and being present at all operations. This is hardly favourable in terms of advancing quality care, indeed a criticism made of Miss Nightingale by the MP Joyclyn Percy (who had come to the Crimea as an admirer of her work) was disappointed to see that she felt she had to do everything herself. A strategy that is likely not to facilitate the empowerment of others.

Florence was a strong willed and clear thinking individual who was persistently driven to achieve her goals in life. Unlike many Victorian women, she had found a singleness of purpose and in spite of family and social opposition, sought to promote herself into a career as a social reformer. She was able to use her contacts in parliament and social networks to lobby for change and achieved access to the ears of the great and the good. Even if she was not recognized as the force behind the agenda, her hand was often on the back of the men making the changes. Her success in influencing the health and welfare of British soldiers is the most remarkable example of her capacity to make decisions and act as an empowered individual (Grint 2000, Bostridge 2008).

Clinically competent and clinically knowledgeable

Possessing clinical knowledge and being seen as clinically competent are central pillars to being recognized as a clinical leader (Cook 2001, Stanley 2006a–c). This may be the most contentious point, for it is proposed that Florence had neither. For although Miss Nightingale wrote extensively about nursing, hospital reform and nurse education, her insight into these issues came not from personal experience (other than as a patient and invalid herself) but from the reports of an army of informants and sympathizers. There is certainly no information to support her use of evidence-based practice in the application of nursing care (Larson 1997). For example, in 1864, she described a scientific article demonstrating that cholera was a water-borne infection, as having no practical value (Smith 1982). It

may be claimed that she possessed a rich vein of knowledge about sanitary matters and nursing, but the contention here is that it was based on limited clinical knowledge and experience. In *Notes on Nursing* (1860) the shortest chapter (three pages) is on 'Personal cleanliness' and in relation to providing for patient hygiene, Miss Nightingale has but one sentence: 'The various ways of washing the sick need not here be specified – the less so as the doctors ought to say which is to be used' (Nightingale 1860/2008 Ed). Therefore, a most fundamental clinical nursing skill is not commented upon either because Miss Nightingale felt it was the medical officers' duty to instruct the nurse or because Miss Nightingale lacked experience to offer detailed instruction. The book was not intended as an instruction manual for nurses, but neglected to offer insights into something as fundamental as patient hygiene. This brings into question Florence's practical insights into common nursing duties.

In terms of her knowledge it is worth considering where her information came from. Clearly during the conflict in the Crimea, Florence was able to observe male orderlies caring for the ill and wounded soldiers and she expressed great respect for the nursing undertaken by Mary Clare Moore and her Nuns from the Sisters of Mercy, (two were Mary Stanislaus Jones and Mary Gonzaga) but as stated, it is questionable that as the Superintendent of Female Nurses that Florence did any actual nursing herself. After her return from the Crimean conflict, Florence did no nursing and sought advice and information from a number of informants. It was these people who delivered the knowledge and clinical insights that may be attributed to Florence Nightingale. Most notable are Mary Jones the Superintendent of St John's House nursing sisterhood. According to Bostridge (2008, p. 427) Florence 'regularly consulted Mary Jones on all manner of nursing issues' and that she 'constantly deferred to the older woman's greater practical experience'. In fact Mary Jones is somewhat overlooked as a real pioneer of modern nursing.

It is also worth noting, that in terms of practical experience Mary Seacole, a Jamaican born Creole who also cared for the sick and wounded during the Crimean war, 'far outdid Nightingale's experience of hands on nursing' (Bostridge 2008, p. 273).

Displaying her values and beliefs through her actions

In this area there can be little doubt that the choices Florence Nightingale made about her 'career' were

driven by a deeply religious commitment to serve and do her duty. As such she agreed to go to the Crimean conflict and to serve as the Superintendent of Female Nurses. She was in the process of volunteering to go when Sir Sydney Herbert offered her the opportunity which was to define her life. But if she had not been passionately committed to the ideals of care and improving the health of her fellow humans she may not have taken up this opportunity with such dedication. She faced genuine risks to her health and reputation in travelling to Scutari.

Another example of Florence being committed to her values is reflected in an incident towards the end of her life. Miss Nightingale is often considered a pioneering nurse researcher, however, she was more precisely a statistician who had committed much of her life to understanding and using statistics to influence others. This is illustrated in the following example: Florence had initially left 2000 pounds in her will to endow the first ever chair of applied statistics in England at Oxford University. However, because Sir Francis Galton (the most eminent statistician of his day who would be responsible for overseeing the chair's work) refused to exclude 'research' from the endowment brief as Nightingale had wished, she revoked the bequest in her will. Research it seemed was not something Florence was interested in, but statistics were her life-long passion (Reid & Boore 1987) and as with other aspects of her life she was passionately committed to her principles.

Why does this matter?

In 1999 at the annual conference of 'Unison' (a British health workers union) it was suggested that Florence Nightingale should be dropped as an icon of nursing because of her authoritarian style. At the conference it was noted that Florence had a submissive attitude to medical officers, antipathy towards feminism and her success in the Crimean was questionable (Grint 2000). However, what Florence Nightingale achieved was remarkable and essential. The intention here is not to diminish the influence or achievements of Florence Nightingale. Merely to point out that there are different types of leaders and leadership, therefore if nurses influence on health care and nursing as a profession is to flourish and positively impact on the quality of health services there is a need to recognize these differences and nurture the development of different types of leaders and leadership.

It is almost a century since Miss Nightingale's death. Why does it matter if Florence Nightingale was or was not a clinical leader? The point here is that if nursing

and the quality of patient care is to improve, clinical nurses need to be supported and fostered to develop their bedside leadership skills as well as leadership for the academic, political and managerial domains, as Miss Nightingale did. To lead at the bedside, nurses need to use evidence-based practice, effective decision-making skills, effective communication, their clinical talents and display their values and beliefs about care.

We can not all be, and neither should we aspire to all be Florence Nightingales'. It is a sad reality that the types of leaders who function at the bedside are often relegated to the back pages of history (Stanley 2007). Nurses such as Mary Seacole, Mary Jones, Mary Clare Moore, Mary Stanislaus Jones, Mary Gonzaga and even Mary Stanley (or maybe it's just that nurses called 'Mary' are more easily neglected) are all central contributors to the development of the nursing profession. However, as a profession it is incumbent upon us to recognize these 'other' leaders, to remember and celebrate their achievements and to see the significance of their contribution to clinical nursing and quality patient care.

Conclusion

Clinical leaders...bedside leaders matter. They make a real and significant difference to patient care and the lives of the people they engage with. They are the nurses and health professionals who go to the edge, take a risk, take a chance and forge ahead by virtue of their values and beliefs as they are acted out in their care-based activities. These are Congruent Leaders. They are approachable and open, visible in practice settings, positive role models, clinically knowledgeable and competent, empowered decision makers with their values and beliefs about care on show. There are a few parts of Florence's character which fit the profile of a clinical/Congruent Leader. However, Miss Nightingale was not a clinical leader. She found other ways to be a leader in nursing and a powerful and successful role model she was for the academic, political and managerial domains. But there are other ways to lead and other types of leaders and leadership that nursing and the health service needs to foster, discover and recognize (Rafferty 1993).

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