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A Critical Exploration of Nursing Leaders Storied Experiences of Phronesis within the COVID-19 Pandemic

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health and Rehabilitation Sciences

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Abstract

In this critical hermeneutic study, I critically explore nursing leaders' storied experiences of phronesis within the COVID-19 pandemic. Phronesis is the ability to perceive a situation and deliberate well in order to determine the best course of action for human beings. Theoretically informed by critical social theories, I considered how the enactment of phronesis was often performed according to normative discourses and the socio-political historical situatedness of nursing leaders. I utilized Frank's (2012a) narrative dialogic analysis to interpret and bring into conversation participant stories, and multiple discursive voices. Based on Pinkola Estés (1995), I use the metaphor of the wild wolf to frame the narratives of nursing leaders' who, I argue have at times, relegated their 'wildish nature' to the poorest lands of their authentic self.

Amidst the chaos and unknowns of the early months of the COVID-19 pandemic nursing leaders collaborated with leadership "command teams" to make decisions based on institutional and government directives. The findings in this research demonstrate how phronesis is often performative based on socially constructed leadership models that have created images of how to be a competent and effective leader. Managerialist discourses and hegemonic cultures are argued to lurk in the shadows and to sustain the health care hierarchy shaping nursing leaders' prioritization of dominant views over nursing perspectives.

While nursing leaders in this research often framed their thinking and actions based on altruistic values and beliefs, the discrepancy between values, beliefs and actions was also evident in the data. It is argued that a consideration of what is "best" in nursing leadership practice requires reflexivity and a critical understanding of how discourses influence one's identity and world view. Phronesis was revealed through nursing leaders

embodied sense of the right thing to do and the articulation of clear principles that underpin decision-making and actions. Recognizing how hegemonic cultures shape one's 'self' has the potential to transform and (re)connect nursing leaders with their authentic selves. Additionally, interpretations offer considerations for nursing leadership education and professional development by taking into account how managerialist and institutional discourses shape nursing leader's ontological perspectives. Greater attention to critical perspectives, reflexivity, knowing and naming institutional discourses and cultures has the potential to inform a reimagining of phronesis as a 'way of being' for nursing leaders.

Keywords: Critical, Hermeneutic, Narrative, Nursing Leader, Phronesis, Practical Wisdom, Reflexivity

Summary for Lay Audience

This research critically examines nursing leaders' storied experiences of practical wisdom during the COVID-19 pandemic. Practical wisdom (also known as phronesis) involves deliberating and making decisions considering what is best for human beings. I consider what insights might be gained by critically examining how practical is enacted by nursing leaders and the broader context surrounding decision-making, judgement, thinking, and actions.

Critical perspectives were used in this research to uncover and challenge some of the taken-for-granted norms within nursing leadership. Emerging from this research are different ways of thinking about how institutional contexts shape nursing leaders thinking, behaviors and actions. Within the chaos and uncertainty of the pandemic, many nursing leaders defaulted to traditional hierarchies out of concern for the safety of patients, staff, and families. Nursing leaders performed the role of being confident, in control and visible which aligns with organizational management. Nursing leaders articulated a strong regard for nursing however, actions did not always align with the values, beliefs, and mandate of nursing. Within this research, nursing leaders drew on experiential, personal and intuitive knowledge to consider the best course of action. The findings reveal that nursing leaders often prioritized government or institutional mandates with little consideration of the ripple effect on patients, families, and communities. Front-line nurses were often not included in decision making regarding their work or on formal leadership decision making team(s). The findings in this research suggest that wisdom involves more than intelligence and experience. Practical wisdom requires nursing leaders to consider how their values, beliefs and dominant institutional norms shape decision making and the power institutions wield over who they are, how

they behave and what they believe. Critical reflexivity holds potential for nursing leaders to extend their focus inward in order to discover hidden assumptions, biases, and dominant ways of seeing, thinking, and acting.

This research offers a new way of thinking about how to be a nursing leader by inviting nursing leaders to question what informs one's position and actions. Wise nursing leadership includes attention to critical reflexivity and a prioritization of nursing values and nursing knowledge. The findings from this research have implications for nursing leadership professional development, nursing education and health professional education.

Co-Authorship Statement

I, Karen Jenkins acknowledge that this thesis in monograph format is a result of collaborative efforts. In this thesis the primary intellectual contributions were made by the first author who led the design and implementation of the research (developed the ethics application; conducted the literature reviews, participant recruitment, data collection b) led the data analysis and c) led the writing of the thesis. The contribution of Dr. Sandy DeLuca and Dr. Elizabeth Anne Kinsella was primarily through the supervision of the research, theoretical and methodological guidance, reflexive dialogue throughout the process, and intellectual and editorial support.

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I wish to express my immense gratitude to my supervisor Dr. Sandy DeLuca who encouraged and supported me to “release [my] the imagination”, venture into the underbrush and discard my ideological frames of reference. Your “super” “vision” ignited my ability to fly freely in my writing. You provided me with a safe circle of support to return to when I needed to feel grounded, supported, inspired and re-released to fly again. I would also like to thank Dr. Elizabeth Anne Kinsella for inspiring my interest in phronesis and for your thoughtful, gentle and inspiring wisdom. You have been an inspiration to me since I first met you and I am so very grateful to have had you as a guiding light throughout this journey. I am also grateful for the support and wisdom of my committee member Dr. Derek Sellman for challenging me throughout my writing to “look up” from my work, to be open-minded and to intentionally seek out different perspectives. I wish to thank my HPE colleagues, of which there are many, who have all patiently listened, responded and supported. I must include a special shout out to my special colleague/co-worker and friend, Dr. Jodi Hall who has taught me so much about research, human beings, kindness, love, and myself.

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ain't no dry run" which to me has meant we don't get any "do-overs" so in life, we have to try to get it right. I think ...we got it right. Thank you to my beautiful Marmie who I know has been with me despite her dementia and my Dad for teaching me many life lessons, supporting me and loving me. Thank you to my sista Kelly. You have been so supportive, checking in, asking me how it was going, and giving me space to work despite the roller coaster ride of managing mom's failing cognition. My speech in grade 7 was about you as you were my hero and you still are. Many people have asked me, "So what are you going to do when you are done?" For me, this journey is not a stepping stone, but rather a personal growth experience of getting to this point and being open to what comes next.

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Performance of Texts

Within my thesis I have utilized various fonts to represent distinct voices in the texts. The performance of texts reveal multiple meanings that signify the everydayness of and discursive nature of experiences. The various fonts serve as visual cues that a different ‘voice’ is speaking. In this way, the integration of textual voices engages the multiple voices in a dialogical performance that invites readers to follow along. I have included a ‘Legend’ below that explains the different fonts that represent the different textual voices.

Myself as researcher/theoretical and scholarly literature

Nursing leader participants

My reflective journal writing

Other fictional/media voices

Preface: “Women who Run with the Wolves”

Phronesis is a way of being (Jankelson, 2013). For Heidegger (1927/2010), who we are, how we think, and act is based on our socio-cultural, historical worlds. However, one’s innermost ‘being’ is often hidden from one’s consciousness. “Women who Run with the Wolves” by Pinkola Estés’ (1995), is a call to women to unearth their inner wild wolf self and embrace the qualities that they have repressed in response to patriarchal dominant ideologies regarding how women should be and behave in society. Pinkola Estés (1995) suggests there are similarities between the wild nature of wolves and women:

Wolves and women are relational by nature, inquiring, possessed of great endurance and strength. They are deeply intuitive, intensely concerned with their young, their mates, and their pack. They are experienced in adapting to constantly changing circumstances; they are fiercely stalwart and very brave (p. 2).

Although not explicitly stated, Pinkola Estés (1995) appears to draw on feminist thinking to describe the wild woman archetype explaining that the inner psyche of ‘being wild’ exists in all human beings. My supervisor first told me about this book when I was in the midst of my analysis experiencing uncertainty, searching for a way to frame my work. I was hesitant to read the book because I assumed some people think of wolves as aggressive which is not how I personally believe nursing leaders might wish to be portrayed. However, I then received a sign. I don’t really believe in signs, but this one was right in front of me. I could not ignore it.

My supervisor encouraged me to “dwell in the uncertainty”. The use of the term “dwell” is alluring and calming, and I envisioned myself walking in the woods “dwelling” in my thoughts and imagination. This was not the case. For me, it was more

like, “stressed out in uncertainty”. I had been reading and re-reading the transcripts, reading other narrative research, trying to write my thoughts, spending days/hours thinking...obsessing almost, and it felt like, “I knew the road was there, but I couldn’t find it. The way was not marked and there were so many paths to take” (Blackie, 2016, p. 151). I had been reading and searching for something to fit this narrative work, a book, a movie, poetry. As I read the first chapter of the book “Women Who Run with the Wolves”, Pinkola Estés’ (1995) ideas immediately resonated with my thinking and this work. However, I was still hesitant about the “wolf” image. Then I experienced a sign.

As I write this, we are in the midst of the COVID-19 pandemic. I am an essential caregiver for my mother who resides in a long-term care residence. To be a caregiver, one is required to receive a weekly COVID-19 test. On this one particular week (during the “stressed out in uncertainty” phase), I was going for my weekly test when I met Nurse Jackie (no affiliation with the television series). As I sat down to answer Jackie’s perfunctory list of questions regarding my health and travel status, I noticed that beside Jackie’s name tag was a sticker of a wolf. I had never seen stickers on nurses’ name tags; Jackie told me that they had stickers for children, however, weren’t allowed to use the stickers because of the potential of contamination, so she put one on her name tag. I asked her why she chose a wolf and she told me because of the book, “Women Who Run with the Wolves” and asked me if I had read it? I told her I was in the middle of reading it and shared that I was thinking about using it to frame my research findings. I asked what she thought of using some of the ideas in the book to portray one’s inner authentic nurse (wolf)? Nurse Jackie enthusiastically agreed. Jackie’s identification with the book encouraged me to open my mind to the resonance of the wolf metaphor for other nurses

and my data. It was the encounter I needed at that moment to use the book and I am grateful I did.

Chapter One: “Following the Tracks”

Background

Phronesis is an ancient Greek term that Aristotle considered the highest form of wisdom. For Aristotle (trans. 2011), phronesis is a form of wisdom directed toward morally informed actions that are beneficial for human beings. The notion of phronesis has interested me for over a decade because of its compelling potential within health professional practice. As a practicing nurse, I have often questioned why there is so much emphasis on policies and procedures governing practice and why nurses are not ‘allowed’ to make decisions for clients based on their nursing knowledge. Nurses are professionals with years of training and are required to demonstrate their accountability and knowledge through professional exams and annual reviews. Flaming’s (2001) belief that phronesis should be the guiding light for nursing practice impressed upon me an understanding that nurses possess important *nursing* knowledge regarding their clients/patients and clinical situations that should be valued and at the forefront of nurse’s thinking and actions within practice.

Returning to pursue my doctoral degree has enabled me to further delve into phronesis. My interest evolved to a consideration of phronesis in nursing leadership because in my thinking, nursing leaders possess experience and have the power to influence change within institutions. Phronesis has been touted as a key virtue of leaders (Cathcart & Greenspan, 2013; Küpers & Pauleen, 2013). However, there is limited understanding of how phronesis is enacted in the practice of nursing leaders. McKenna and Rooney (2019) suggest that phronesis is needed to manage the complexity of problems within society and that “wisdom research can act as a corrective to the crisis in leadership practice and the shortcomings of leadership theory” (p. 649).

This research responds to the call for “wisdom led leadership” by exploring the experience of how nursing leaders figure out the right way to do the right thing in complex situations. Phronesis demands more than just knowledge and skill of leadership practices, it requires the capacity to perceive oneself; to reflexively examine one’s motives, one’s thinking and actions and to admit one’s weaknesses and to possess the will to be a virtuous leader (Schwartz & Sharpe, 2010).

My original intent was to explore the enactment of phronesis within nursing leaders’ practice however, as the inquiry progressed, critical views unfolded. As such, this study pushes boundaries in several ways. This inquiry has been uncomfortable and has challenged my thinking through my engagement with critical perspectives. This inquiry also navigates the boundaries of what may be considered normative nursing leadership research into the tangled underbrush where critical and discursive perspectives of nursing leadership exist. Within the nursing leadership literature, critical perspectives, and attention to phronesis are limited. As such in Chapter One, I begin with an explanation of phronesis and then ‘follow the tracks’ of nursing leaders by presenting nursing leadership literature that focuses on phronesis, the COVID-19 pandemic as well as the discourse surrounding nursing leadership. In Chapter Two, I traverse into the underbrush and discuss my research intentions, my epistemological, ontological and axiological positions. I explain my methodology and resonance of critical theory with hermeneutics that is critical hermeneutics. Chapter Three takes the reader deeper into the enchanted forest where one will find my theoretical influences that include selected theories of Judith Butler, Michel Foucault, and critical leadership studies. In Chapter Four, I describe the participants and my decision to use narrative methods along with

Arthur Frank's dialogical method to analyze participant stories. I discuss how I discovered the theoretical perspectives lurking in the shadows and how I bring them into dialogue with the participant narratives and other voices. I make explicit my positionality and the tension I experience of being 'a wolf in sheep's clothing', emphasizing reflexivity and attention to trustworthiness. In Chapter Five I begin to share my findings that are partially framed based on several ideas from Pinkola Estés' book and the metaphor of wolves. This chapter explores nursing leader stories within the early months of the pandemic when COVID-19 is likened to a predator circling the wolfpack resulting in uncertainty, chaos, and anxiety surrounding the pending arrival of COVID-19. Chapter Six continues to discuss the findings focusing on the performative nature of nursing leaders' stories of phronesis. Chapter Seven highlights the leg traps or challenging situations where nursing leaders had to make difficult decisions. Nursing leader stories reveal the hegemony and managerialist cultures of health care. In Chapter Eight I share the Russian fairy tale of Vasalisa; a story that contains multiple meanings. I relate the notion of intuition to nursing leaders' authenticity and ontologic reflexivity which I discuss as being bound to phronesis. The final chapter is a call to my wolfpack (nurses and nursing leaders) to become reflexive and take a second sober look at the performance of nursing leaders, the culture of health care and the devaluing of nurses and nursing knowledge. I also call on my wolfpack to consider reflexivity and phronesis as a way of being or ontological perspective for nursing leaders. A glossary of terms is included in the appendices.

Phronesis

The notion of phronesis was coined by the ancient Greek philosopher Aristotle (384-322 BCE). Aristotle was a student of the famous philosopher Plato. Plato believed wisdom was linked with theoretical knowledge and therefore a rare quality possessed by few. Whereas Aristotle saw phronesis as a form of wisdom linked with experience that focused on human concerns (Smartwood & Tiberius, 2019). Within Aristotle's famous, *Nicomachean Ethics*, the term prudence is used to describe phronesis which is defined as "a state of grasping the truth, involving reason, concerned with action about what is good or bad for a human being (Aristotle, trans. 1999, p. 154).

For Aristotle, phronesis involves *techne*, *episteme* and *praxis*. *Techne* is the artistic or craft knowledge and skills of professional practitioners (Kinsella & Pitman, 2012). *Episteme* is scientific knowledge (Flyvberg, 2001). *Praxis* is morally informed action (Aristotle, trans. 2011). Aristotle posits two types of wisdom: phronesis which is a form of wisdom that is concerned with human beings, and theoretical wisdom (*sophia*) which is "an understanding of how the world and the creatures in it actually are" (Smartwood & Tiberius, 2019, p. 13). Smartwood and Tiberius (2019) suggest one may have theoretical wisdom without phronesis, however one must possess theoretical wisdom to be a *phronimos*. "Phronimos" is the term Aristotle uses to describe someone who possesses phronesis.

Aristotle describes phronesis as both an intellectual and moral virtue meaning someone who possesses phronesis is intelligent, but also possesses the will to do what is morally right. Aristotle believed that human beings are inherently good and strive to achieve happiness or *eudaimoia* (to live well and act well) (Aristotle, trans. 2011, p. 5).

Aristotle distinguishes two kinds of virtues: intellectual and moral. Moral virtues include courage, moderation, liberality, magnificence, greatness of soul, ambition, gentleness, friendliness, truthfulness, wittiness, and justice. Intellectual virtues include wisdom, comprehension, and prudence (phronesis). For Aristotle, phronesis stands alone as both an intellectual *and* moral virtue yet one does not possess phronesis without possessing all of the other virtues.

Phronesis is a “characteristic that is bound up with action, accompanied by reason, and concerned with things good and bad for a human being” (Aristotle, trans. 2011, p. 120). For Aristotle, possessing phronesis involves the ability to deliberate about the correct choice of action drawing on the virtues. Each moral virtue consists of an excess and a deficiency, and it is the mean, or the point that achieves the correct balance between the two, that the phronimos is aiming for. Someone who possesses phronesis deliberates well and is able to accurately draw upon the right balance of virtues in order to choose a course of action that is best for human beings (Sellman, 2012). For example, Aristotle refers to courage as the mean between fear and confidence.

Phronesis involves judgment which Aristotle describes as the ability to “distinguish, judge, decide or determine...” (Aristotle, trans. 2011, p. 128). For MacIntyre (1981) “choices demand judgment and the exercise of virtues requires therefore a capacity to judge and to do the right thing in the right place at the right time in the right way” (p. 152). Interestingly, Aristotle contends that judgement involves a component of sympathy towards others and involves making decisions that are equitable (Aristotle, trans. 2011). Thus, wise leaders who possess phronesis draw on various forms of knowledge, guided by intellectual and moral virtues to inform noble actions that serve

the common good.

Contemporary perspectives surrounding phronesis suggest phronesis involves thoughtful, open-minded deliberation and perceptiveness of contextual factors that are at play within situations (Jenkins et al., 2018). Phronesis also involves reflexivity which involves thinking deeply about, and critically questioning one's position(s) of power, values, beliefs, assumptions, judgements, and biases (Kinsella, 2012; McCorquodale & Kinsella, 2015). Frank (2012c) describes the process of acquiring phronesis as confrontations. "Practical wisdom becomes visible only at moments of confrontation when something significant is at stake. The history of such moments guides future choices, less as specific precedents and more as gradual shifts" (Frank, 2012c, p. 64). Frank (2012c) further explains that within today's world, the enactment of phronesis or making choices are never in isolation but rather, always in relation to other people and socio-historical political contexts. As such, within health care institutions, phronesis is directed towards morally committed actions that involve the capacity to reflexively recognize ideologies and discourses that may be influencing one's beliefs, values, and motives (Kemmis, 2012; Schwartz & Sharpe, 2010).

More recent attention to phronesis considers embodiment as an important element (Kinsella, 2018; Küpers, 2013). Küpers (2013) states, "...embodied practical wisdom...involves sensing, perceiving, making choices, and realizing actions that display appropriate and creative responses under challenging circumstances through bodily ways of engagement" (p. 24). Attention to embodied knowledge affords practitioners with potentially rich and meaningful ways to make sense of and attend to challenging practice situations (Kinsella, 2018).

The term phronesis is sometimes translated to practical wisdom. Throughout this

thesis, the term phronesis will be used, however practical wisdom may at times appear in quotations.

Literature Review

In this chapter, I review three areas of scholarly literature that substantiate the directions of my research study. The literature review was conducted by searching the following databases: Eric, Scopus, CINAHL, Google Scholar, and Medline. The following terms and combination of terms were searched: practical wisdom, phronesis, wisdom, nurse leader, leadership, manager, supervisor, and administrator. Over the past decade, the main body of nursing leadership literature has focused on leadership competencies, emotional intelligence, leadership styles, education, and professional development (Crawford, Omery, & Spicer, 2017; Fast & Rankin, 2017; Prezerakos, 2018; Schick-Makaroff & Storch, 2019; Siren & Gehrs, 2018). This body of work has been important for advancing nursing leadership and substantiating the need for nursing leaders in health care. There is a relatively small number of nursing leadership research studies that utilize a critical perspective. The following will summarize the nursing leadership literature that converges with phronesis, nursing leadership and COVID-19. In the first section I review popular nursing leadership frameworks such as transformational leadership, authentic, human-centred, and ethical leadership along with common critiques of these frameworks. I will then review select studies in the area of nursing leadership and wisdom and/or phronesis followed by a summary of some of the more recent research related to nursing leadership and the COVID-19 pandemic.

Nursing Leadership Frameworks

The role nursing leadership plays in nursing job satisfaction, ensuring high quality patient care and outcomes has been well documented (Cummings et al., 2010; Fischer &

Nichols, 2019; Goedhart, van Oostveen & Vermeulen, 2017; Wong, Cummings & Ducharme, 2013). Within the literature, authentic and transformational leaders have been highlighted as having a positive influence on nursing staff empowerment, creating supportive work environments, retention of nurses and improved patient outcomes (Spence Laschinger, et al., 2011; Wong, Cummings & Ducharme, 2013).

Within transformational leadership theory, charismatic leaders are said to possess vision, and inspire and motivate employees (Avolio & Bass, 1988; Hutchinson & Jackson, 2012). Five practices of exemplary transformational leaders have been identified as: challenging the status quo and seeking new solutions; possessing and inspiring vision; empowering others; role modeling active engagement in change; and, encouraging the heart which involves showing appreciation and understanding people personally (Kouzes & Posner, 2017). Transformational leadership has been popularized within nursing leadership research, education, and practice. The Canadian Nurses Association (CNA) and the Registered Nurses Association of Ontario (RNAO) have adopted transformational leadership as the framework for nursing leader professional development and other leadership guidance documents (CNA, 2009; RNAO, 2013).

Authentic leadership is suggested to be a leadership development theory that focuses on advancing the self-awareness of the leader and follower (Avolio & Gardner, 2005). Avolio and Gardner (2005) suggest authentic leaders are relational, self-aware, possess a positive moral perspective and ability to self-regulate. Self-regulation “is the process through which authentic leaders align their values with their intentions and actions” (Avolio & Gardner, 2005, p. 325). Authentic leaders possess moral capacity and draw upon values and beliefs to make ethical decisions (Avolio & Gardner, 2005). This style of leadership resonates with the notion of phronesis and the intention to do what is

best (Laschinger & Fida, 2015; Bamford, Wong and Laschinger, 2013). Within both authentic and transformational leadership styles there exist similarities to phronesis such as the ability to manage competing values and priorities within transformational leadership; the self-regulation of authentic leaders as well as the moral and ethical obligations exhibited by both transformational and authentic leaders.

Within nursing and health care, leadership styles have been reified through discourse and thus appear as natural and socially acceptable (Cutcliffe & Cleary, 2015). Both authentic and transformational leadership styles purport the ideologies of staff empowerment and autonomy which leads to job satisfaction and improved patient outcomes (Boamah, 2017; Boamah et al., 2018; Gottlieb, 2021). However, the focus on patient outcomes may unintentionally devalue the importance of relationships which is a cornerstone within nursing. Transformational leadership has been critiqued because of its individualistic focus on the leader and lack of attention to broader issues such as social justice, power, and the gendered nature of leadership (Hutchinson & Jackson, 2013). As well, the current managerialist “ethos” within health care pressures nursing leaders to prioritize budgets which may undermine the priorities of transformational leadership (Fast & Rankin, 2017; Thorne, 2021, p. 151). Within the COVID-19 pandemic, Rosser et al. (2020) argue that nursing leaders have reverted to, “a master-servant model of leadership that fails to draw upon the collective intelligence, knowledge, wisdom, and intellectual capital of the wider nursing community” (p. 2).

Human-centred leadership is a leadership theory developed by nurses for nursing leaders that focuses on ontology, or an inner-outward process of being a nursing leader (Leclerc et al., 2021). Leclerc et al. state:

Because of this inner-outward process, outcomes emerge organically via cultures of excellence, trust and caring as is the nature of a complex adaptive system such as health care. If the paradigm is shifted to consider complex adaptive systems with a human-centred leadership approach, those at the point of service are the influential leaders who should be empowered to make decisions pertinent to the care provided. (p. 302)

Leclerc et al. (2021) believe that focusing on nurses and nursing results in a healthy work environment that leads to improved patient outcomes.

Gottlieb et al. (2021) recently published a new framework for nursing leadership entitled, “Strengths-Based Nursing and Health Care Leadership” (SBNH-L). This framework is built on the core values of Gottlieb’s (2013) “Strengths-Based Nursing and Health Care” which is an approach to nursing practice that focuses on client strengths as opposed to risks and/or deficits. Gottlieb’s SBNH-L framework is based on *nursing* practice, and “goes beyond” authentic and transformational leadership theories to include attention to nursing leader’s and nurse’s “agency, autonomy and empowerment” (Gottlieb et al., 2021, p.173). This leadership theory is relatively new and has not, as yet, been evaluated for its effectiveness in practice.

Nursing Leadership and Phronesis

An extensive review of the literature yielded three studies that discuss nursing leadership and phronesis. Pesut and Thompson (2018) explore the formation of wise nursing leaders. They do not use the term practical wisdom or phronesis, yet focus on characteristics of wise people. For Pesut and Thompson (2018), those who possess a tendency to wise leadership possess “exceptional insight into human development and life matters, look for deeper meaning, tolerate ambiguity, have compassion, are other and

purpose focused, and recognize the limits of knowledge” (p. 125). Pesut and Thompson (2018) suggest nursing leaders can acquire wisdom through more advanced professional development strategies such as disorienting dilemmas or what they term “heat experiences”. Heat experiences are when one’s views are challenged by different perspectives causing one to engage in a process of “elevated sense making” where one examines one’s embedded belief system (Pesut & Thompson, 2018, p. 123). For Pesut and Thompson, leader development requires “difficult inner work” that focuses on reflexivity of the self (p. 123). Pesut and Thompson (2018) suggest wisdom is not a fixed characteristic and is dynamic, evolving, and building within an individual.

Linderman et al. (2015) explore the enactment of wisdom and phronesis offering interesting insights. Linderman et al., (2015) adapted a “sense-making methodology” (based on the work of Dervin, 2010) to study nursing leaders embedded wisdom (p. 293). “The concept of sense-making posits that as humans move through time we constantly and reflexively evaluate our behaviors and perspectives - as seen in our ideas, decisions, emotions, and preferences (Linderman et al., 2015, p. 293). Linderman et al. (2015) adopt this methodology to interview and analyze nursing leaders’ thought processes as leaders work through and make sense of situations. Linderman et al. (2015) coined their method the “Sagis adaptation sense-making methodology” which includes specific questions that prompt participants to explore and discuss gaps in situations where they experienced barriers to moving forward (Linderman et al., 2015, p. 295). Nursing leader interviews were analyzed by breaking down their qualitative responses into storylines that delineate nursing leader’s action steps when making sense of complex situations (p. 294). Themes revealed insights of nursing leaders including “reconciling paradoxical aspects of situations or relationships” (Linderman et al., 2015, p. 296). The authors posit this model

as a methodology to better understand the embedded wisdom or “deep smarts” of experienced nursing leaders (Linderman et al., 2015, p. 294).

Cathcart and Greenspan (2013) utilized Benner et al’s (2009) notion of practice articulation as a methodology to illuminate the development of practical wisdom within nursing leaders. Building on the work of Benner (1999), small groups of nursing leaders within the same organization were asked to write about an experience of either a best practice or a break down in practice and then read their narrative to their peer group (Cathcart & Greenspan, 2013, p. 965). The process of writing and reading to the group enabled nurse managers to learn from each other and revealed common habits in practice. Nursing leaders with more than five years’ experience exemplified phronesis in greater depth than those with less than five years’ experience. Experienced leaders demonstrated perceptiveness, critical and ethical thinking when balancing the demands of the organization (ie. managing budgets) with nursing values (i.e. providing high quality care). Through a process of reflection, gathering more information and consulting with others, nurse managers exemplified phronesis. Nurse managers discussed how they learned: to reflect on pre-conceived notions; to recognize that every situation is unique and warrants taking time to explore all aspects; and the limitations of formal rules to guide decision-making (Cathcart & Greenspan, 2013, p. 968). The findings from this research highlight the value of nursing leaders sharing narratives of phronesis to ensure moral and ethical issues related to human caregiving remain a priority within health care (Cathcart & Greenspan, 2013).

There seems to have been a renewed interest in ethical leadership within nursing leadership literature. The notion of moral goodness is often referred to within nursing leader frameworks, however how it is enacted, particularly within nursing leadership, has

not been well developed (Pesut & Johnson, 2013). Ethical leadership has traditionally been viewed as an important aspect of nursing leadership however, there has been a decreased emphasis on ethical issues in nursing leadership due to the prioritization of efficiencies over the inherent values of nursing practice (Schick Makaroff et al., 2014). According to Hutchinson and Jackson (2012) there has been too much emphasis on leadership styles and these authors suggest new ways of thinking about leadership that focus on ethics and values is needed (p. 19). Mannix et al., (2015) posit aesthetic, embodied leadership to address the diminishing moral imperative within nursing leadership practice. For Mannix et al. aesthetic leaders are humble, willing to challenge policies to do what is right, and “embody principled practice”, grounded in professional nursing practice (p. 1605).

Phronesis has received some attention within nursing literature, the notion of phronetic, virtuous and humble leaders have been gaining interest in fields of business/management and education (Branson, 2009; Crossan et al., 2016; Küpers, 2013; Newstead et al., 2019; Schein & Schein, 2018; Schwartz & Sharpe, 2010). For Newstead et al. (2019) the focus within leadership has been on developing *effective* leaders, when what is needed today are effective *and good* leaders. These authors suggest that within the theoretical and practical work surrounding leadership, there remain several gaps, one of which is a better understanding of the enactment of virtuous leadership (Newstead et al., 2019, p. 9).

Wisdom is an elusive concept that is conceptualized differently depending on one’s worldview (Westrate et al., 2019). A consideration of worldviews has interesting implications for the study of phronesis as contexts potentially influence what is considered right or best. Contextual norms potentially influence leaders’ priorities when

deciding what is best within complex situations. Phronesis affords nursing leaders the ability to discern choices and actions considering one's moral intentions (Kinsella, 2012). Jenkins et al. (2018) posit a broadened view of phronesis that includes attention to embodiment, open-mindedness, perceptiveness, and reflexivity. Embodiment in practice denotes a deeper bodily understanding of practice situations (Küpers, 2013). Open-mindedness involves being curious and "holding beliefs in an open-minded way" (Sellman., 2011, p. 200). Perceptiveness involves insight and attention to the various nuances of situations; and reflexivity is "an ongoing critical appraisal of self and others in action; understanding how our actions are formed by our context and our relationships to others" (Norton & Sliep, 2018, p. 46). Phronesis is more than the ability to make sound judgements, it requires the desire *to be* practically wise (Schwartz & Sharpe, 2010). Phronesis affords nursing leaders novel ways of thinking more reflexively about embodied values and beliefs and how these inform choices, decisions, and actions. Despite the interest in wise ethical leaders, the above research studies are limited in two important ways. First, nursing leadership practice in health care is complex and much of the leadership research seems to focus on characteristics of good leaders and what is missing is the day-to-day nuances of practice. Second, there were few studies that utilize a critical perspective. For Cutcliffe and Cleary (2015), a lack of critical research within nursing leadership may be due to "an unwillingness to raise these issues into the consciousness of the nursing community" (p. 822).

Fast and Rankin (2017) explore the discursive/institutional milieu of nursing managers in an acute care institution in Canada. In their institutional ethnography, Fast and Rankin reveal the conflicting demands nursing managers navigate as a result of

“New Public Management” (NPS) systems where the mantra is “to do more with less” (p. 3). New technologies, data systems, measurement of productivity along with the demand to monitor labour expenditures are dominating nurse managers responsibilities. Despite the wisdom of nursing managers, Fast and Rankin (2017) discovered nursing managers prioritized managerialist budgetary priorities over patient care and nurses’ well-being. Nursing leaders in Fast and Rankin’s research creatively found ways to optimize nursing resources in order to meet the staffing level standardized quarterly reports. Fast and Rankin (2017) highlight the limitations of current nursing leadership theories and the need to problematize the work of nursing leaders within existing new public management systems of health care.

Nursing Leadership and COVID-19

With the advent of COVID-19 in 2020, the leadership literature has shifted to highlight leadership strategies, resources and lessons learned from the pandemic. The pandemic has upended the practice of nurses and nursing leaders. Predictions and priorities regarding health care within the 21st century have changed due to the COVID-19 pandemic. Nursing leaders have risen to the challenges of the pandemic, working around the clock to navigate the changing landscape, demonstrating flexibility, courage, and resilience. Within the pandemic, nursing leaders have been caught between a “fire and sword” compelled to make critical decisions that have been perceived by some as overreacting, while others suggest nursing leaders have been unprepared (Tourish, 2020, p. 263). Nurse leaders have experienced a tension between doing what is right for patients versus the “business concerns” of the institution (Newham & Hewison, 2021, p. 84). Newham and Hewison (2021) suggest that ethical codes of conduct and other guidelines/rules have been non-existent for nursing leaders within the COVID-19

pandemic which has paradoxically refocused priorities on patient care freeing nursing leaders to engage with key stakeholders and make innovative practice decisions unencumbered by managerial and institutional imperatives. As well, the pandemic has required nursing leaders to become more relational. Newham and Hewison (2021) state, “During the pandemic, there has been a greater emphasis on the importance of relationships both vertical, between leaders and their teams, and horizontal, between colleagues for integration of support networks” (p.87). For Newham and Hewison (2021) the pandemic has generated a relational form of leadership that has fostered collaboration and a principle-based approach leading to improved judgement and decision making. There is growing interest within nursing leadership literature for ethically and morally informed approaches (Schick Makaroff, & Storch, 2019). Several scholars have suggested that at the heart of good nursing leadership is phronesis (Cathcart & Greenspan, 2013; Linderman et al., 2015). This research responds to the call for new and novel ways of looking at nursing leadership by critically exploring the storied experience of phronesis within the COVID-19 pandemic. Phronesis demands more than just knowledge and skill of leadership practices, it requires the capacity to reflect on oneself; endeavoring to consider one’s motives, biases, assumptions; to admit one’s weaknesses and to possess the will to ‘do the right thing’ in complex situations (Schwartz & Sharpe, 2010).

A critical exploration of nursing leaders’ storied experiences of the enactment of phronesis within the COVID-19 pandemic responds to the call for new directions within nursing leadership research (CNA, 2009; Jefferson et al., 2014). Jefferson et al. (2014) suggest there is a need for more contextually based leadership research that explores the lived experience of nursing leaders. Pesut and Johnson (2013) state, “The moral art of

nursing administration, or nursing leadership, is perhaps one of the least developed areas in nursing philosophy and is deserving attention” (p. 52).

Chapter Two: “Into the Underbrush”

Research Methodology

Within qualitative research Denzin and Lincoln (2018) argue that it is imperative that the researcher articulates one’s epistemological and ontological assumptions, theoretical perspectives, methodology, and methods, in order to adequately posit knowledge claims and to maintain quality in qualitative research. In this chapter, I will present the research questions, methodological approaches, and epistemological, ontological, and axiological perspectives, underpinning this research. Theoretical perspectives will be presented in Chapter Three.

Phronesis is an elusive concept and because of this it difficult to explain and articulate what phronesis looks like in real world practice (Kinsella & Pitman, 2012). As part of my early dissertation work, I published a paper that examined Aristotle’s notion of phronesis and contemporary views of phronesis (Jenkins et al., 2018). Based on this work, in this thesis I consider what insights might be gained by exploring and critically examining how phronesis is enacted in nursing leadership and the broader context surrounding decision-making, judgement, thinking, and actions. My original intention was to explore the enactment of phronesis in general within nursing leaders, however with the advent of the COVID-19 pandemic, it seemed inevitable that much of the focus of nursing leaders would include decision making surrounding the pandemic. The intention of my research thus became to utilize critical perspectives to gain an understanding of nursing leaders storied experiences of phronesis within the COVID-19 pandemic. My critical hermeneutic inquiry explores such issues by considering the following research questions:

- What are nursing leaders' storied experiences of phronesis within the COVID-19 pandemic?
- How is phronesis enacted in nursing leaders' practice? What political, social, cultural, historical, and economic forces influence the enactment of phronesis?
- What forms of knowledge and discourses shape nursing leader's stories?

These were not my original research questions. I did not begin this research with a particular critical perspective in mind, however through the process of writing, reading, re-reading, and engaging in dialogue with the participant stories, my reflections, and my supervisor, critical theories were brought into the conversation to contextualize my emerging interpretations.

I am mindful that conducting qualitative research is an emergent endeavour, and that further questions, or more salient questions arise as a result of interviews, ongoing reading, and reflection on my interpretations.

Into the Underbrush Surrounding the Forest: Critical Hermeneutics

A critical hermeneutic methodology was employed to explore nursing leaders' storied experiences of phronesis within the COVID-19 pandemic. Critical hermeneutics is not unlike Caputo's (1987) radical hermeneutics which calls into question the "fix we are in" by facing up to the realness of everyday worlds, to attend to the difficult questions and to resist the temptation to find the easy way out (p. 3). Critical hermeneutics crosses the perimeter of traditional hermeneutic research heading into the thick underbrush surrounding the forest. Within the underbrush, I bring hermeneutic philosophy, drawing on the work of Martin Heidegger, together with critical leadership studies and critical theoretical perspectives of Butler (1997, 1999, 2005) and Foucault (1972, 1975, 1980, 2000, 2001, 2008) to inform the proposed critical hermeneutic inquiry. Denzin and

Lincoln (2018) describe the contemporary qualitative researcher as a “bricoleur” suggesting there exist multiple ways researchers’ piece together their inquiry drawing on a variety of theoretical, interpretive, and methodological tools (p. 11).

Heidegger’s Hermeneutics

Martin Heidegger was a German philosopher who was interested in understanding the meaning of ontology. Within philosophy, Heidegger’s hermeneutics is often not considered a methodology, however his philosophical tenets may be seen to underpin a perspective on hermeneutics. Some of his key tenets include ontology, Dasein, being-in-the-world, and the care structure (Horrigan-Kelly et al., 2016).

Heidegger’s primary focus was “being-in-the-world” or the way human beings exist and are involved with the world (Dowling, 2005, p. 133). For Heidegger (1927/2010) being-in-the-world is always being with others. Heidegger uses the term *Dasein* to describe the *being of* a human being (Jenkins et al., 2021). Dasein is a priori and represents the ontological nature of human beings (Heidegger, 1927/2010). Dasein’s being-in-the-world with others does not only mean being with human beings but denotes being with the things in the world. Heidegger (1927/2010) refers to “the they” which represents the ideologies, beliefs, norms and values of the world (p. 169). For Heidegger, Dasein initially exists in the world inauthentically assuming a “passive role” to ideologies and norms (Horrigan-Kelly et al., 2016, p. 3). In Dasein’s being with others, Dasein can choose a potential possibility to live either inauthentically or authentically (Horrigan-Kelly et al., 2016). Dasein’s mode of understanding the self in the world is through interpretation. Interpretation encompasses presuppositions or preunderstandings which are what comes before or prior to Dasein (Heidegger, 1927/2010). Recognizing what comes before, influences one’s interpretation of experiences.

According to Heidegger (1927/2010), one cannot apprehend or know an independent reality because human beings cannot separate their thinking and views from who they are. In other words, for Heidegger, humans are born with certain ways of being (i.e., biological sex, race, and socio-economic status), and these form interpretive views of the world based on the norms of the society and contexts in which one is immersed. For Heidegger (1927/2010), one's contextual, socio-cultural, and historical situatedness limits one's interpretive possibilities. Heidegger suggests interpretation is a process whereby understanding is enhanced or deepened through a hermeneutic circular process (p. 152). For Heidegger (1962) interpretation is not about acquiring information but "rather [as] the working-out of possibilities projected in understanding" (p. 189). Characteristics of hermeneutics include an acknowledgement that the lived experience is an interpretive process and that human "consciousness is not separate from the world of human existence" (Dowling, 2005, p. 133).

Dreyfus explains Heidegger's hermeneutics as "a hermeneutics of everydayness and a hermeneutics of suspicion" (Dreyfus, 1991, p. 34-35). A hermeneutics of everydayness involves investigating people in their everyday lives. A hermeneutics of suspicion recognizes that human's inner Dasein (being-in-the-world) is always partially covered or hidden requiring the investigator to realize that what appears real is distorted and not fully accessible (Dreyfus, 1991). Thus, hermeneutics is a reflective endeavor that essentially goes deeper than the surface level, and attempts to uncover that which cannot initially be seen; discovering the taken-for-granted, and critically questioning what lies beneath experiences (Crotty, 2003).

Heidegger (1927/2010) uses the term "care" to discern the ontological nature of human beings that exists prior to one's situatedness in the world. For Heidegger, "care

lies before” and forms the will or intentions of human beings (p. 188). “What one cares about, or values is influenced by one’s socio-political and cultural contexts” (Jenkins et al., 2021, p. 2). However, as Paley (2000) suggests, Heidegger’s notion of care does not assume that all humans are ethically concerned with doing the right thing. For example, one may be concerned with, or care about climbing the corporate ladder however have little concern for those who impede their progress. Heidegger’s notion of care is always moving forward or directed towards the future which has interesting implications when thinking about phronesis and the future potential outcomes of decisions and actions.

The tenets presented are not all encompassing of Heidegger’s hermeneutics. I have chosen to highlight the ones that are of significance to this research. I acknowledge there are many more. Phronesis is an elusive term that has the potential to be broadly applied to nursing leadership experiences however it is not my intention to “spin the web of signification” by claiming the interpretations of nursing leaders experiences of phronesis within this research are to be revered (Paley, 1998, p. 820). I therefore recommend that readers consider the findings as insights or possibilities that contribute to new ways of seeing differently.

Critical Inquiry

Critical social theory attends to adopting a questioning stance towards the status quo and seeks to uncover inequities in the everyday taken-for-granted social structures of institutions and society. A critical approach considers how power is implicated in experiences, shaping and influencing and seeks to change hegemonic oppressive systems (Kincheloe & McLaren, 2005; Laliberte Rudman, 2013; Paradis et al., 2020). Key concerns within a critical paradigm include attention to power, discourse, ideologies, privilege, oppression, social justice, and systems of oppression (Crotty, 2003). The

term ‘critical’ refers to the capacity to inquire ‘against the grain’: to question the conceptual and theoretical basis of knowledge and method, to ask questions that go beyond prevailing assumptions and understandings, and to acknowledge the role of power and social position in health-related phenomena. The notion of critical inquiry includes self-critique and a critical posture with regards to qualitative inquiry (CQ, 2018). The theoretical perspectives that inform this research are from a critical paradigm including Michel Foucault, Judith Butler, and critical leadership studies. These theories are discussed further in Chapter Three.

Critical Hermeneutics

Kinsella (2006) posits the combination of interpretive and critical approaches afford rich possibilities to inform critical hermeneutics within qualitative research. For Kinsella (2006) the potential of bringing together the two perspectives lie within a “metaxalogical” space whereby the two perspectives meet, not to converge, but rather to reveal new possibilities together in dialogue (p. 12). Kinsella (2006) states, “insights garnered from critical perspectives with respect to power, the potential misuse of language, the recognition of distinct but potentially communicative selves, and an acknowledgement of ‘the fix we are in’ can inform hermeneutic inquiry” (p. 11).

Within hermeneutics, the role of the researcher involves the interpretation of texts (broadly conceived) and includes attention to the historical and social circumstances of individuals. For Heidegger (1927/2010), discourse constitutes “the mode of being of the understanding and interpretation of everyday Dasein” (p. 162). For Heidegger, language and communication is discourse. For Foucault, language is a way of representing knowledge, however “discourse is the production of knowledge through language” (Hall, 2003, p. 44). There are similarities between critical and hermeneutic perspectives with

regards to analyzing textual or linguistic expressions. For Heidegger (2010), language is at the core of understanding (Heidegger, 1927/2010). Within critical paradigms all language is discourse. Since discourse influences what humans speak about, there are parallels regarding the notion of the historical discursive nature of narratives which often reveal ideologies through discourse (Rudman, 2013).

For those working with interpretive and critical paradigms, there are multiple ways of interpreting the reality (ontology) and of what constitutes knowledge (epistemology) (CQ, 2018). Similar to the abundance of creatures that exist within the underbrush surrounding an enchanted forest, through a critical hermeneutic lens, each individual possesses their own unique view and interpretation of reality.

From an interpretive or critical perspective, reality is constructed or influenced by discourse and one's socio-cultural, historical, and contextual situatedness in the world. Through a critical and hermeneutic lens, interpretation and understanding is based on the discursive nature of both researcher and participant's subjective and ontological perspectives (CQ, 2018). Viewed through a critical lens, what can be known regarding the meaning of experiences questions assumptions, power, discourse, and surface-level explanations of experiences.

Hermeneutics and the process of coming to understanding is often referred to as a circular or spiralling process moving between the parts and the whole (Heidegger, 1927/2010, p. 147). Adding a critical lens invites a spiralling dialogue between the voices of participants and myself, as well as other voices from literature, fiction, media, acquaintances, and my advisory committee. Trede et al. (2009) describe the spiralling nature of dialogue within the interpretation of texts in hermeneutic research as "critical transformative dialogues" (p. 13). For Trede et al. (2009) critical transformative dialogue

involves “being open and yet sceptical, being comfortable with ambiguity, and being comfortable with extending one’s comfort zone represents blending deeper with critical perspectives” (p. 14).

Ontological Perspective

Ontology is the study of the nature of reality and how one exists in the world (Heidegger, 1927/2010). Zignon (2018) argues that human beings possess the ability to attempt to understand the nature of existence and to shape their world. Similar to Heidegger, my perspective is that humans not only shape their world, but worlds shape them. Heidegger’s (1927/2010), *Being and Time* is an example of the human desire to understand the nature of being in the world however the inability to truly understand ontology is what opens up possibilities for “the creative release of potentialities that already exist right here and now but are covered over, or trapped within, or held back by that which currently is” (Zignon, 2018, p. 17). My ontological assumptions are that reality is often hidden, constructed through socio-economic, political, historical, and cultural contexts, dominant discourses, and shaped by relations of power.

My view of reality or my ontological perspectives are influenced by my positionality which include my biases, assumptions, values, and beliefs. Heidegger (1927/2010) believed that what one cares about is what one is attracted to or feels is important and these interests are influenced by ideologies. I understand my ontological perspectives to be dynamic and iterative shaped by discourse(s), my past and present experiences, my positionality and normative ideologies and therefore my ability to fully comprehend my ontological perspective(s) is partial and difficult to apprehend due to the embedded nature of these perspectives.

Epistemological Perspective

Roberge (2011) states, “hermeneutics and critical theory observe the world from two different points of view, but these can nevertheless ‘interpenetrate’ each other to form multiple points of convergence” (p. 7). Based on this thinking, as a researcher I take a reflexive stance towards knowledge and the research process. Knowledge (epistemology) is shaped by power relations including the relationship between researcher and participants (Eakin et al., 1996). My positionality is inextricably tied to knowledge production. What is ‘known’ about the phenomena of interest is historically situated within the time frame of this research and my situatedness reflecting the dominant discourses and ideologies (Guba & Lincoln, 2004). Based on these assumptions regarding the nature of reality and knowledge, I recognize that my ability to know is limited by my own positionality. My intention is to problematize normative ideologies to afford new possibilities or ways of seeing and understanding nursing leadership and phronesis.

Axiological Perspective

“Axiology is the study of values and how they influence the research process” (Paradis et al., 2020, p. 844). Examining values and beliefs is intrinsic to the enactment and inquiry surrounding phronesis. Within this research, I acknowledge that my values shape this inquiry and am interested in understanding how values influence nursing leaders decision making and what forms of knowledge are valued and underpin decisions (both phronetic decisions and non-phronetic decisions).

For this research, and the research questions, critical hermeneutics allows me as a researcher the ability to listen to and interpret nursing leaders’ storied experiences as well as explore the ideologies and discourses informing participant stories (Missel &

Birkelund, 2019). I chose critical hermeneutics because I believe “existence itself is a hermeneutic experience” (Heidegger, 1927/2010; Zignon, 2018, p. 161). Critical hermeneutics invites one to question and interpret the shadows behind the stories and construction of knowledge(s), revealing what is valued, and what is not. I chose critical hermeneutics along with narrative methods to interpret the discursive constructed stories of experiences of praxis that ‘reveal’ the values, beliefs and subjectivities of nursing leaders. Nursing leaders exist within a complex culture of social-political, institutional, and biomedical discourses that influence their subjectivity.

I chose critical hermeneutics and narrative methods versus critical narrative because critical narrative approaches emphasize attention to marginalization, exclusion, and inequities (Laliberte Rudman, 2013). Although one could potentially interpret the narratives attending to these concepts, I chose not to because nursing leaders are not considered a marginalized, excluded group, and are in fact the opposite. A critical framework is central to this research because it privileges practice, action, consequences, discourses, and performances (Denzin & Lincoln, 2018).

Chapter Three: “The Enchanted Forest”

Theoretical Influences

Enchanted forests are believed to be places of mystery and magic. They are often liminal spaces where those who enter experience some life changing event. In fables, enchanted forests sometimes represent ambiguity, darkness and the unknown. At other times, they represent adventure, and afford a place of transformation and new understanding. The creatures of enchanted forests are often magical providing guidance and revealing hidden truths about the world. Within this research, the enchanted forest represents the theoretical perspectives informing this work. I began this work thinking from outside the enchanted forest, which is a neutral place in which most people exist within the status quo. The lure of what I might find in the enchanted forest drew me to enter. In order to discover new possibilities within this research I encountered the work of Judith Butler, Michel Foucault, and critical leadership studies (i.e. magical creatures of the forest) which have helped to bring theoretically informed insights to my interpretations of participant narratives.

In this chapter, I introduce the theoretical perspectives that guide this research. My written thoughts and words are not “prescriptive”. At most, they are tentative and perhaps thought provoking. The nursing leadership narratives are interpreted using critical theories however, this work is also constructed in dialogue with substantive literature including critical leadership studies. Jackson & Mazzei (2018) state, “thinking with theory does not come at the end of anything but is emergent and immanent to that which is becoming” (p. 719). The notion that thinking with theory is a process that is ontological, or continually becoming, resonates with the way my analysis unfolded. I use the theoretical perspectives of Foucault and Butler to open possibilities or “unthought

approaches” to thinking about the experience of phronesis (Jackson & Mazzei, 2018, p. 720).

Within a critical paradigm, I employ Judith Butler’s theory of performativity and theory of subjectivity, Michel Foucault’s theories regarding discourse, power, knowledge, and subjectivity. As well, I draw from critical leadership studies, a relatively new and emerging field. Judith Butler is a philosopher and gender theorist whose theories and writing have been influential in studies of race, gender, queer, ethics, and disability studies. Judith Butler’s work is, at times, difficult to read and my attempt, was humbling, however I persevered because her theories created resonance and meaning within this research.

Michel Foucault’s methods and theories are considered seminal within a critical paradigm. Some suggest that Foucault’s work is post-structuralist, however Foucault himself did not wish to be associated with any particular school of thought (Gordon, 1994). Foucault’s work is vast and complex, and I do not claim to be an expert in the full spectrum of Michel Foucault’s writing, I have found some of his work generative in thinking through aspects of my doctoral work. Similar to Foucault, I am interested in gaining new and more effective ways of seeing. In particular, I wish to make visible what I have come to see as the ‘lone wolves’ within nursing leadership who I contend have become lost in the ‘enchanted forest’. In this work and my thinking, enchanted forests represent institutional and managerialist ideologies and discourse.

I will first discuss Butler’s performativity theory, followed by Foucault’s theories of discourse, power and knowledge, and the subject. I will then describe Butler’s theory of subjectivity which partially builds on Foucault’s notion of the subject. I conclude with a description of critical leadership studies

Performativity Theory: A Butler-ian approach

Judith Butler's theory of performativity was first introduced in her well-known book, *Gender Trouble: Feminism and the Subversion of Identity* (1990/2002). Butler's later work expanded this theory however, this research will focus on the original theoretical work presented in Butler's original *Gender Trouble*. The ensuing explanation of Butler's performativity theory is my attempt to understand her dense writing. The intent of Butler's (1990/2002) theory of performativity is to question the "what" and "how" regarding the discursive nature of inner and outer gender identities. Within this research I apply Butler's theory of performativity to nursing leaders experience of phronesis that may, to some, be an inaccurate application of the theory which Butler created to reveal gender performances. However, for my work, Butler's descriptions of performance of gender resonates with my thinking regarding how nursing leaders perform an outer role that may be contradictory to their inner genuine self. This will be explored further within Chapter Five.

For Butler, there is a fantastical or elusive relationship between the outer body and one's inner soul or identity. The body "stylizes" or constructs the appearance of gender on the outside or outwards through one's body which is enacted based on idealized norms of gender (Butler, 1999, p. 177). Butler suggests that the enactment of gender is based on normative ideals and "coherence is desired, wished for, idealized..." (p. 173). It is unclear to me what Butler means regarding coherence. Is coherence in relation to norms, or coherence between outside identity and inner soul, or perhaps both. I assume Butler is referring to the former as Butler further states, "Such acts, gestures, enactments, generally construed, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained

through corporeal signs and other discursive means” (p. 173). In other words, the outer bodily ways one acts (signs), which in my interpretation means, how one dresses, speaks, walks, moves, and gestures, are enacted in response to how one *should* act to fit the requisite norms. Jenkins and Finneman (2018) state, “performativity does not exist as a repeated set of norms performed in compliance with the law, but the law in essence, mobilizes these actions” (p. 160).

Butler utilizes the example of Drag to exemplify the performance of gender. One’s outer appearance is an illusion that hides one’s inner true gender identity. Butler’s (1990/2002) example of Drag delves into the “parody of the performance” of Drag as an outer performance of gender that may or may not exemplify one’s true gender identity (p. 174). For Butler, the parody of Drag denaturalizes and disrupts gendered norms. The notion of gender performance resonates with how one performs or enacts the role of a health professional, a nurse, or a nursing leader whereby the performance of one’s outer identity may not represent one’s true inner identity. The way one talks, acts, gestures, dresses and thinks, are imitations, based on the surrounding culture and institutional norms. Within a Butler-ian approach to health professional leader’s identity there potentially exists a dissonance or misalignment between one’s inner genuine self and one’s outer performative health professional self. The performance of leadership roles might be “reconceived as a personal/cultural history of received meanings” (Butler, 1999, p. 176). Again, Butler discusses gender, however my reading of *Gender Trouble* resonated with leadership performance of roles that fit with the leadership norms within health care. Butler (1999) posits “styles of the flesh” that represent various “styles” of gendered bodies. Similarly, there exist leadership styles that can be seen as “cultural fictions” or constructed behavioural norms that conceal one’s genuine self (p. 179).

Butler suggests through repetition, the act of or performance of gender has legitimized the binary of gender identities. For Butler, gender is not a stable identity and is maintained or transformed through a “stylized repetition of acts” (p. 179). In other words, gender is temporal and there exist possibilities to displace one’s enacted gender to reveal the truth of one’s inner identity. Butler calls this a “failure to repeat” (p. 179). For Butler, “the performance of gender is not a choice and gender norms determine the acceptability and intelligibility of the subject” (Jenkins & Finneman, 2018, p. 159). Similarly, nursing leaders’ performance of various roles such as competent, knowledgeable, and confident may not be consciously by choice and are required to sustain one’s position and fit within health care institutions. For Butler, performativity of gender and the parody of the performance offer sites of resistance because the performance of gender can be purposeful and/or deceiving which destabilizes the normative ideologies surrounding gender identity.

Butler’s performativity theory has been critiqued because of the denseness of the writing and the lack of emphasis on individual agency (Boucher, 2006). In my reading of performativity and subjectivity theory, I found some ideas extremely difficult to relate to and apply. My attempt to understand performativity and subjectivity theory is based on my own close reading of the theories and acknowledge that I may have misunderstood or interpreted some of the ideas. In order to attempt to better understand Butler’s work, I read other texts, such as Brady and Schirato’s (2011), “Understanding Judith Butler” to help clarify my understanding.

Performativity theory suggests subjectivity is shaped and conditioned by external forces, and yet, for Butler, there remains a site of possibility for agency and resistance. Mambrol (2018) questions whether performativity can be a site of resistance when one

can never fully apprehend an understanding of the psychic nature of one's identity. Schep (2012) suggests the hegemonic nature of the theory is somewhat exclusionary of those who experience ambiguity knowing and understanding their bodies and identities. Schep (2012) highlights how transgender folks complicate the notion of performance of gender by arguing that gender for them is non-performative versus performative. Schep (2012) suggests that the problem with Butler's theory, is that it is too "all encompassing" of all gender identities as performative which has resulted in a hegemonic framework of gender identities (p. 873).

Butler's performativity theory is critiqued for its focus on the individual performance negating the influence of contextual forces, lack of attention to demographics, and a consideration of the people one is performing for, which potentially influence the performance (Lloyd, 1999). General critiques discuss the performance of language (Cavanaugh, 2018). Nonetheless, despite these critiques, performativity theory has been readily taken up in feminist studies and has been applied within many fields such as, anthropology, linguistics, ritual studies, political studies, disability studies and theatre.

Foucault's Theories

Scheurich and McKenzie (2005) describe three main areas of Foucault's work: The analysis of discourse, the analysis of power and knowledge and the question of the subject (p. 849-850).

The Concept of Discourse

Foucault was interested in *discourse*, which is a linguistic concept that evolves around language and practice (Hall, 1997). For Foucault discourse is defined as:

A group of statements which provide a language for talking about – a way of

representing the knowledge about – a particular topic at a particular historical moment...Discourse is about the production of knowledge through language. But ...since all social practices entail *meaning*, and meanings shape and influence what we do – our conduct – all practices have a discursive aspect. (Hall, 1997, p. 72)

Discourse produces the objects of one's knowledge. Foucault is not suggesting that nothing exists outside of discourse, but rather nothing has *meaning* outside of discourse (Hall, 1997, p. 75). Within health care institutions discourse endorses certain kinds of knowledge about the way things are, prescribes certain ways of talking and thinking which governs what is considered knowledge and, how this knowledge "acquires authority, a sense of embodying the 'truth' about it" (Hall, 1997, p. 73). The state of knowledge and what counts as truth is produced by institutional apparatuses. For Foucault (1975/1995) the apparatus "assumes responsibility for all aspects of the individual" (p. 235). The apparatus will be described in the next section.

Power and Knowledge

For Foucault, power operates in a net-like manner and is therefore multi-directional and everywhere which suggests human beings are all immersed in nets of power (Foucault, 1980, p. 98). Power is often negative, however can be productive, producing things including knowledge and discourse (Hall, 1997). Foucault describes the movement of power as capillary-like and deeply rooted in behaviours and bodies (Hall, 1997, p. 77). Hall (1997) states, "He [Foucault] places the body at the centre of the struggles between different formations of power/knowledge. Foucault describes the operation of knowledge and power within institutions as "institutional **apparatus** and its **technologies** (techniques)" (Hall, 1997, p. 75). Within the institutional apparatus,

knowledge and power are techniques of regulation wielded through discourse, administrative measures, and regulations. Foucault's ideas regarding discourse, power, and knowledge are similar to some of the Marxist beliefs regarding ideologies, however Foucault argues against the Marxist notion that relations of power and knowledge are reduced to classes, as he believes that throughout society there exists an inseparable link between power and knowledge. Foucault rejects the notion that the Marxist "bourgeois" or ruling class possess truth and knowledge, because Foucault believes that one cannot possess truth and knowledge outside of discourse (Hall, 1997, p. 76). Foucault (1980) argues:

Truth isn't outside power. ... Truth is a thing of this world; it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its 'general politics' of truth; that is, the types of discourse which it accepts and makes function as true, the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned ... the status of those who are charged with saying what counts as true. (p. 131)

Subjectivity

Traditional notions of subjectivity, consider the subject to be an autonomous individual who consciously and unconsciously has a sense of themselves, and makes conscious choices and actions. For Foucault, the subject is "produced within discourse" in two ways: The discourse itself produces 'subjects' – figures who personify the particular forms of knowledge which the discourse produces. The subjects have the attributes we would expect as these are defined by the discourse: the madman, the hysterical woman, the homosexual, the individualized criminal and so on. (Hall, 1997, p.

55). The other way subjects are produced within discourse is in the way that one becomes subjected to discursive forms of power through language, culture, and the surroundings one is immersed in that become meaningful and appear as the norm (Hall, 1997). For Foucault, not all individuals become subjects of discourse and he therefore posits that the subject changes with shifts in contextual and historical circumstances. Foucault (1975/1995) states “the soul is the prison of the body” which suggests that one’s inner self is hidden or suppressed within the interior of one’s outer body (p. 172). In Foucault’s later work, he acknowledges that through a critique of regimes of truth, which denotes “a critical labor of thought upon itself”, individuals can reflexively recognize their subjectivity (Ong-Van-Cung, 2011, p. viii).

Foucault’s theory of subjectivity has been extensively critiqued within various schools of thought. A general critique is that Foucault neglects to discuss external contextual forces that influence the subject such as the environment and institutions. In the famous televised debate between Noam Chomsky and Foucault in 1971 (Philosophy Overdose, 2021), Chomsky argues that there exists a moral sense within human beings and that individuals possess their own unique human nature, however Foucault disagrees suggesting that human nature is historically situated based on discourse. For Foucault, any real concept of truth does not exist outside of discourse, which has been disputed by positivist thinkers (Wilkin, 1999).

Within feminism, a major critique of Foucault’s theories is the lack of attention to gender which reflects “women’s absence from the active production of most theory within a whole range of discourses over the last 300 years” (Weedon, 1987, p. 13). However, Foucault’s theories have provided feminist thinkers with a means to analyze and produce valuable new and conceptual knowledge. Other feminist critiques posit

Foucault did not address gendered power relationships and how males' figure prominently within discourse (Baker, 1990). Feminists are concerned with Foucault's reductionist notion of the subject and the subject's inability for moral agency and resistance (McLaren, 1997). Butler addresses these concerns within her theory of subjectivity.

Butler's Theory of Subjectivity

In *The Psychic Life of Power* (1997), and *Giving an Account of Oneself* (2005), Butler explores the complex problem of understanding identities in relation to societal norms. For Butler (1997/1999), the use of the term "the subject" is not the same as the person, or the individual. "The subject" is in relation to the definition of subjection which is defined as, "The act or fact of being subjected... to a conquering or sovereign power...to a superior...placed or set underneath" (Oxford English Dictionary, n.d.). Power is external to and precedes the subject. The subject is a part of linguistic discourses constructed from external forms of power (i.e., ideologies and discourse) (Butler, 1997). When one talks about oneself, the self is described according to the discourses that have shaped one's identity. For Butler (1997), "Subjection consists precisely in this fundamental dependency on a discourse we never chose but that, paradoxically, initiates and sustains our agency" (p. 2). In Butler's early work, *The Psychic Life of Power*, she builds on Foucault's ideas that the subject is formed through the external pressure of discourse pushing the subordination of the subject. Butler uses the term *psychic* to describe the external, unconscious discursive pressures (i.e. ideologies, discourse and norms) that form the subject's identity. For Butler, identity is attached to the subject. Butler (2005) veers from Foucault's thinking in her book, *Giving an Account of Oneself*, where she introduces the possibilities of agency within the subject.

For Butler (1997) there is a double action to subjection that is circular whereby the agency of a subject is a result of one's subordination (p. 12). Butler distinguishes two ways power is implicated by/within the subject. There is power that forms the subject and power that the subject possesses and utilizes. Together these two forms of power are enacted by the individual, however the former becomes embedded within the identity of the individual, whereas the latter can be employed through one's agency. For Butler, an individual's agency complicates power because of one's conscience. "Conscience is the means by which a subject becomes an object for itself, reflecting on itself, establishing itself as reflective and reflexive" (Butler, 1997, p. 22). The desire to understand oneself and become reflexive denotes an ambivalence within one's agency to subject to forms of power. Butler posits power forms the subject; this does not imply that one's agency is fully controlled by conditions of power (p. 13). "Agency exceeds the power by which it is enabled" (Butler, 1997, p. 15). The subordination of the subject is not by choice, but neither is it a necessity" (p. 20). Butler suggests that the ability to turn on oneself to see the psychic dimensions of power that have formed one's subjectivity requires an intentional effort that is possible through reflexivity. For Butler, recognizing or becoming reflexively aware of the sources of power that have formed one's subjectivity, weakens the hold power has on the subject:

Butler's theory of subjectivity accounts for how performative acts reify one's belief in a stable identity. Based on Foucault's notion of critique of self and regimes of truth, Butler (2005) states:

Thus if I question the regime of truth, I question, too, the regime through which being, and my own ontological status, is allocated. Critique is not merely *of* a given social practice or a certain horizon of intelligibility within which practices

and institutions appear, it also implies that I come into question for myself. (p. 23)

Subjectivity is shaped and conditioned by external forces, and yet remains a site of possibility for agency. As a researcher, it is important that I pay careful attention to how power and hegemony influence nurse leader participant's positioning, agency and subjectivity throughout the research process.

Critical Leadership Studies

Critical leadership studies (CLS) are an emerging field of study. Critical leadership studies draw on several key theoretical perspectives including post-structuralism, critical realism, feminism, deconstructionism, and post-colonial theory (Collinson, 2011). Collinson (2018) discusses three main paradigms within the field of leadership: heroic, post-heroic, and critical studies (p. 261). The heroic approach values individual leaders and the notion of the *effective* leader. Heroic approaches focus on traits and characteristics which are seen in many traditional leadership theories which assume that leaders make decisions and followers “merely carry out orders from ‘above’” (Collinson, 2018, p. 261). Post-heroic leadership approaches emphasize collaboration between leaders and followers, considering contexts and culture, however, downplay the existence of power.

Critical leadership studies seek to denaturalize what constitutes norms of leadership, questioning hegemonic and taken for granted ideologies within mainstream leadership/managerialist perspectives (Collinson, 2011). Research within CLS, centres around issues of power, leader/follower dynamics, the influence of discourse and contexts, and dualisms such as leader/follower and leadership/management (Collinson, 2011; Collinson, 2018). Critical leadership studies acknowledge the link between power

and identity and the performance of roles that have been shaped by organizational cultures (Collinson, 2011). Gender and the influence of male dominated ideologies is a key area of interest within CLS (Hearn & Collinson, 2017).

Recent work within CLS focuses on power, conformity, and resistance (Collinson, 2018). Drawing on the work of Foucault, CLS is interested in the dialectics of power between leader and follower which is often paradoxical and contradictory but at the same time interdependent and relational (Collinson, 2018, p. 266). Critical leadership studies identify how the follower plays a significant role within dialectical nature of leader/follower relations and the various meanings of agency for followers (Chalef, 2009; Chalef, 2015; Meindl, 1995). Collinson (2018) suggests a spectrum of follower possibilities exists ranging from followers that are loyal fans of their leader to followers that disguise their dislike of their leader, to followers that overtly resist. Critical leadership studies highlight the potential for follower resistance and view followers as human beings possessing agency, skill, and knowledge (Collinson, 2018). Critical leadership studies acknowledge the reality that leaders' decisions and actions often have unintended consequences which leaders are unable to anticipate. For Collinson (2018) disguised oppositional nature within followers' results in a shifting of power that raises important questions about resistance. Drawing on feminist perspectives, CLS acknowledges the gendered nature of leader/follower relationships as well as the intersecting aspects of race, class, age disability, faith, and sexual orientation.

Lastly, CLS is interested in the embodied nature of leadership. Traditional leadership studies privilege the mind over the body. According to Melina et al. (2013) "leadership is not 'housed' in an individual (a person with a body) but is a discourse that both reveals and constitutes identity (p. xv). Attending to the body potentially affords

new insights into how leaders and followers perform identity through the body enabling one to reflexively understand the self (Melina et al., 2013).

Often in fairy tales and folklores, enchanted forests are places where the main character finds the object of their quest. My chosen theoretical perspectives provided me with the objects of my quest which are the theories I required to analyze and engage in a dialogue with the participant narratives.

*Enchanted Forest Trail
Seek the magic in this place
Guided by my woodland face
Follow the path to the end
There you'll find me waiting, friend*

<https://www.pond5.com/stock-footage/tag/enchanted-forest/>

Chapter Four: “Lurking in the Shadows”

Forests materialise around her to conceal her movements in shadow and it is in this darkness that she always lurks...Colin "BoBliness" Hill

Within this work, shadows were spaces where I found myself lurking, searching for meaning in the narratives, revealing my own situatedness. The challenging stories were often hiding in the shadows. Within this chapter I will discuss my research methods, participants, narrative dialogic interviews, reflexivity, and positionality. My analytic lenses and trustworthiness will also be addressed.

Narrative Methods

Narrative methods were chosen for my research because of the “meaning-making function of narrative” (Riessman, 2008, p. 10). Narrative is a storytelling method that deliberately invites research participants to story their experiences revealing embedded historical, social-cultural, and ideological contextual worlds (Riessman, 2008). For Chase (2018), narrative is, “... a distinct form of communication: It is meaning making through the shaping of experience; a way of understanding one’s own or others’ actions; of organizing events, objects, feelings, or thoughts over time (in the past, present, and/or future)” (p. 549). Through the process of telling stories, participants re-live, re-encounter and re-examine their experience shedding new meaning and understanding.

Narrative makes sense as a method to foster an understanding of phronesis because “narratives are event-centered-depicting human action – and they are experience-centered at several levels” (Riessman, 2008, p. 22). The experience-centred levels that Riessman refers to denote the various stages within the reproduction of storied experiences. For example, there is the storied experience itself, the recounted experience articulated by participants, and the inferences that are added into the narration of an

experience (Reissman, 2008). Narratives depicted as event-centered human action resonates with Aristotle's (trans. 2011) notion of the *process* of phronesis which involves reflection and deliberation resulting in action. I believe the process of thinking, reflecting, and deliberating is similar to the narration of an experience whereby narrators intentionally construct stories based on their discursive social realities, to achieve a certain purpose (Reissman, 2008). Layering a critical hermeneutic lens over narrative methods enlivens the stories bringing to the forefront a view of individual situatedness within broader discourses (Rudman, 2013). For Rudman (2013), "we can only tell stories that make sense in the context in which we exist and boundaries of that context are the larger discourses" (5:14). For me, critical hermeneutics moves behind understanding experience to also examine the "contextual shadows" or discourses and ideologies that are not always intentionally explored within traditional hermeneutics (Clandinin & Connelly, 1989, p. 5). In adopting a critical stance, I am interested in understanding how the enactment of phronesis is influenced by broader discursive socio-political contexts.

Participants

It was my initial intention to recruit eight nursing leader participants, however the "snowball" effect unintentionally occurred within several interviews where participants recommended other colleagues to interview. In total, 12 nursing leaders were contacted however I was only able to schedule 11. The 11 nurse leader participants were currently working or had worked in a nursing leader role. Two were not currently in a nursing leader role however, were still active in nursing, working in other areas. I employed purposeful recruitment of participants. It was important to me to invite Canadian nursing leaders who were experienced because for Aristotle experience is often recognized as key to possessing phronesis (Aristotle, trans. 1999).

I consulted with my doctoral supervisor because of her experience and connections with the broader nursing leadership community. Together we generated a list of nursing leaders who would be suitable to purposively recruit to the study. We discussed whether it would be important to recruit nursing leaders from the same/similar context (e.g., acute care) and decided to recruit from a range of contexts. We reasoned that the enactment of phronesis and the underlying process of thinking, judgement, and action, would be similar, despite context. A list of potential participants was generated from professional nursing networks and nursing leadership groups based on the following criteria:

Inclusion Criteria:

- Nurse participants with five or more years of experience as a nurse, however not necessarily five or more years in a formal nursing leadership position.
- Nurses who are well known or have a reputation as possessing phronesis.
- Nurses who have published (formal or informal) work that implicitly or explicitly reflects phronesis (i.e., perceptiveness, open-mindedness, reflexivity, and virtuousness).

Exclusion Criteria

- Nurses with less than five years' experience
- Nurses who are self-proclaimed leaders
- Nurses who do not speak English
- Nurses who did not or are not practicing as a nurse (Registered RN) in Canada

In this research, “nursing leader” is broadly defined and includes those who are in a formal nursing leadership position as well as those who are informal leaders, and is inclusive of all genders. I have purposely chosen not to share the employment contexts of

my participants to protect their identities. The community of nursing leaders is smaller than we may realize.

Narrative Dialogical Interviews

Riessman (2008) suggests narrative interviews are facilitated rather than conducted describing the process as “two active participants who jointly construct narrative and meaning” (p. 23). Narrative interviewing is a unique form of interviewing style that is dialogic and conversational versus the more traditional question-and-answer type of interview (Riessman, 2008). In keeping with Riessman’s thinking, I provided research participants with an explanation of narrative methods within the letter of information to create a climate that fostered storytelling. At the beginning of each interview, I reiterated the notion of narrative and the meaning of phronesis inviting participants to reflect on and tell stories surrounding phronesis; how they navigated challenging situations, their thinking, perceptions, judgments, emotions, consultation with others, decision making and, their actions. If participants recalled a situation that they felt was a good exemplar of phronesis that did not occur within the COVID-19 pandemic, they were invited to share those stories. Nursing leader participants were encouraged to share stories regarding decisions or choices that in the moment were made with the best intentions, however, may have resulted in negative or unanticipated outcomes.

For Riessman (2008) narrative interviewing requires the researcher to “give up control...” and to “follow participants down *their* trails” (p. 24). During interviews I resisted the impulse to jump in and intentionally remained attentive to encourage participants to story their responses and to follow them down their trails (Riessman, 2008). I had two prepared open-ended questions as well as several prompts (Appendix

C). Interviews were facilitated using Zoom and most were approximately one hour in length. The shortest interview was twenty-eight minutes however, the majority were approximately one hour in length.

Reflexivity

McConnell-Henry et al., (2009) state, “there is no such thing as interpretive research, free of the judgment or influence of the researcher” (p. 9). Reflexivity involves thinking deeply about and critically questioning one’s position(s) of power, values, beliefs, assumptions, judgements, and biases (Kinsella, 2012; McCorquodale & Kinsella, 2015). I utilized reflexivity throughout the research process by keeping a self-reflexive journal, reflexively writing, musing, questioning assumptions, and exploring meanings (Spence, 2017). In order to interrogate my position(s) of power, pre-understandings, assumptions, values, beliefs, and biases, I kept a written reflexive journal to reflect on my ideas and thoughts, as well as other ideas from literature (both academic and fiction), social media, conferences, and conversations with others. I attempted to reflexively examine my thoughts and musings by asking myself, “Why do I think this way?” “Where are these thoughts stemming from?” “Am I listening to the narratives versus hearing?” “What are the stories telling me?” “What is it I want to know?” “Why am I selecting some stories and not others?” “Am I prioritizing certain views over others?” “How are my values and beliefs affecting my actions?” “What assumptions might I be making about participants based on my past experiences?” “How has power operated in my life and practice on a personal, structural, and political level?” These questions enabled me to remain focused, yet open-minded to engage in dialogue with my theoretical lenses, participant narratives, positionality, and personal/professional understandings in accordance with my research questions and methodology (Srivastava & Hopwood, 2009).

Engaging in solitary reflexive practices enabled me to discover a partial, situated, tentative view of possibilities within the analysis/findings.

Assumptions/Pre-understandings

From a Heideggerian (1927/2010) perspective, researchers must attempt to reflexively understand one's socio-cultural historical location to consider one's ontological perspectives or pre-understandings. Researchers attempt to recognize pre-understandings or assumptions in order to be self-aware; to be cognizant of and acknowledge the influence of the researcher's own values and beliefs on the research (Crotty, 2003). Through this process, I identified some of my assumptions as follows:

- My perspective is limited and partial; influenced by my experiences as an educator, a doctoral student, and my privileged perspective as a white female cisgender academic.
- My views are influenced by my career in public health working within a neoliberalist, patriarchal, bureaucratic structure, as well as my privileged academic stance. Nairn (2019) argues, "if nursing knowledge is to be effective it needs to acknowledge the political, particularly in the context of neoliberalism" (p. 1).
- I possess embodied pre-understandings and assumptions based on my privileged position as a nurse academic and faculty member which may shape my prioritization of participants and stories that I am attracted to and resonate with my own cultural, gendered, nursing practice, and academic experiences (Sprague, 2005, p. 132).
- I am interested in phronesis because I possess hope; a hope for nurse leaders who will endeavor to act for the good of human beings. I recognize this is an 'enchanted' sense of hope and acknowledge that the world of health care is one where phronesis may

not be the answer however, as Kemmis (2012) states, “phronesis simply acknowledges uncertainty and aims to act constructively within it” (p. 153).

Positionality “A Wolf in Sheep’s Clothing”

Are we ever sure about who we are and our “selves”? If we are sure, then perhaps we are not open to change (Goff, 2021). For Davies and Harré (1990) positionality is a term used to represent the “discursive production of a diversity of selves” (p. 47). I possess a number of varied subject positions based on my ontological perspectives which influence how I claim to understand my self (selves) and how I interpret the world (Davies & Harré, 1990). These selves include but may not be limited to mother, daughter, partner, student, friend, sister, teacher, researcher, mentor, nurse, female, cisgender, middle-class, privileged white family. I acknowledge these selves do not always define me and are at times in contradiction to one another. Within spaces of tension and contradiction, there exist possibilities for agency:

Once having taken up a particular position as one's own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned. At least a possibility of notional choice is inevitably involved because there are many and contradictory discursive practices that each person could engage in. (Davies & Harré, 1990, p. 46).

Throughout the research process, I was reflexively aware of my subject positions and that these influenced my interpretations. I considered myself an insider because of my position as a nurse and assumed a sense of mutual respect between myself and the nursing leader participants. However, at the same time, as an educator and researcher, I

was an outsider with little experience in a leadership role during a pandemic. I questioned whether my positionality was a limitation. I relied on my insider status as nurse to compensate for my outsider status as an educator/researcher (Bourke, 2014). Similar to Bourke (2014), I have come to reflect on my positionality not in juxtaposition to the research participants but converging with the positionalities of participants. “The research in which I engage is shaped by who I am, and as long as I remain reflective throughout the process, I will be shaped by it, and by those with whom I interact” (Bourke, 2014, p. 7).

Tensions

Conducting this research has been challenging, exhilarating, and has evoked much uncertainty. I struggled with how my location, my reading, my story, my interpretation, analysis, and production of possibilities may for some (myself included) be unsettling. MacLure (2009) suggests theory has the power to offend stating, “that theory’s capacity to offend is also its power to unsettle – to open up static fields of habit and practice” (p. 277).

Participant narratives were mediated and influenced by my positionality as I admittedly chose what stories to include and what to exclude and the theoretical lenses chose to view the narratives through. I recognize that the meanings, understandings, and stories I picked to represent possibilities may undoubtedly be interpreted differently by others. As such, readers are invited to consider other meanings, understandings, and possibilities. As a researcher, I attempted to adopt a “vigilant subjectivity” to understand the depth and richness of the storied experiences of phronesis (DeLuca, 2000, p. 49). DeLuca adopted the term *vigilant subjectivity* to describe the role of the researcher as one where the researcher sees the reciprocity between subject and object and remains

consciously aware of this relationship. Adopting this thinking, as a researcher, I challenged myself throughout the research process to “make strange what is familiar” by acknowledging my own subjectivity in the text (Harding, 1991, p. 150). Building on DeLuca’s notion of vigilant subjectivity I endeavored to remain consciously aware of how my experiences as a nurse who has been in leadership positions, and a nurse who has been led by others, (a wolf in sheep’s clothing) shape my views.

Analysis “Deciding What is a Story”

Narratives are sites of inquiry to interpret the experience of phronesis and the multiple voices within (Frank, 2012a). Reissman (2008) draws on the work of Bakhtin (1981) to suggest the existence of a polyphony of voices within narratives that reflect the hidden ideologies, discourses, and contexts. Reissman (2008) states “stories must always be considered in context, for storytelling occurs at a historical moment with its circulating discourses and power relations” (p. 8). Based on these ideas, I understand narrative methods to involve listening to participant stories, the multiple voices within stories and, the shadows behind the stories, thinking with them not about them (Frank, 2004). Drawing on the work of Bakhtin (1984), Frank (2012a) posits a form of narrative analysis entitled, “dialogical narrative analysis” (DNA). Dialogic narrative analysis seeks to listen to multiple voices and bring them into dialogue with one another, not to seek a singular truth, but to reveal possibilities for humans to “hear themselves and others” (p. 37). For Frank, the stories one tells are never one’s own. “We humans are able to express ourselves only because so many stories already exist for us to adapt, and these stories shape whatever sense we have of ourselves. Selfhood always trades in borrowed goods” (Frank, 2012a, p. 36). For Frank (2012a), dialogic narrative analysis begins from a specified standpoint, however, is never complete as the nature of narrating human

experiences continue on after the research is complete and “stand[s] to be revised in subsequent stories” (Frank, 2012a, p. 37). I began analysis from the standpoint: *Phronesis is a somewhat elusive intellectual and moral virtue that is not well understood in terms of how it is enacted in practice*. Frank (2012a) recommends keeping to one’s standpoint during analysis recognizing that stories are representations of perceptions of experience(s).

In the beginning, I found the process of analysis challenging. I knew the road was there, but I could not find it, so I resorted to what was familiar. I began by reading and reviewing the transcripts, highlighting common themes. As a novice narrative researcher, it was my default to be drawn into a way of thinking about analysis that was based on my previous experience, leaning on what was familiar. I floundered during this time as I felt uncertain, going down one thought path, and then retracing my steps to try another path. At this point, I turned to re-reading Frank’s (2012a) ideas regarding DNA. Frank (2012a) suggests phronetic dialogical analysis involves making decisions regarding what to include and what to exclude, considering what fits together keeping in mind that what is put aside may fit in another version. I found myself drawn to several stories, that were compelling and “call[ed] out as needing to be written about” (Frank, 2012a, p. 43). Chase (2005) suggests that narrative researchers “listen first to the voices within each narrative” versus looking for themes (p. 663). I began to listen to the voices and to see the shadows behind the stories move from back to front. Through a process of writing, I found myself drawn to perspectives that substantiated what I was listening to in the contextual, discursive shadows. When my supervisor introduced me to Pinkola Estés (1995) “Women who Run with Wolves” everything began to coalesce. My standpoint changed to: *Phronesis is the “guiding light” for nurses and nursing practice and viewed this way,*

would be enacted by prioritizing nursing values, beliefs, and knowledge (Flaming, 2001). *Where is nursing in nursing leadership practice?* Frank (2012a) suggests that during analysis a standpoint may change however encourages the importance of keeping one's standpoint at the forefront of one's mind. It wasn't until I began to write that the crafting of my analysis started to unfold. Frank (2012a) states, "The analysis of selected stories takes place in attempts to write" (p. 43). As I wrote, I began to fit the participant stories, the perspectives of the shadows, and other voices together in dialogue; hearing those that resonated and accompanied what belonged and what should be set aside (Riessman, 2008). I brought into dialogue multiple voices that questioned how socio-cultural historical contexts, subjectivities, and hierarchies of power were (co)produced in the narratives and in the spaces between teller, listener, ideologies, discourse, history, and culture (Riessman, 2008).

Analysis also involved close reading of the participant stories through my standpoint and the lens of phronesis (Frank, 2012a). My analysis and findings are therefore interwoven and dialogic with my voice and ontological perspectives, voices of the nurse leader participants and their ontological perspectives, my supervisor, critical theories, critical perspectives of Foucault and Butler, critical management theories, and other voices that entered the dialogue throughout the process analysis.

Riessman (2008) discusses the "ghostly" audiences that influence how the narrative is constructed by participants (p. 105). During the process of analysis, I considered how nursing leader participants performed their stories with specific audience(s) in mind. These audiences included myself, the potential readers of my research findings, and I suggest, the nursing leader participants' ideal selves; a mirror reflection of how they wish others to view them. For Pitre et al. (2013) stories are "*for*

research participants rather than *about* them” (p. 125). Transcripts were analyzed by thinking about how stories and meanings were performed in dialogue between teller and listener with new meanings produced in the dialogue (Riessman, 2008). I understood the notion of a back-and-forth dialogue, including my own narrative woven together, circular and spiralling which resonates with hermeneutics, although not discussed as part of narrative methods. It was important to continually question and consider my own positionality and so I intentionally circled back to be up front regarding my social location, my experiences, and my ontological perspectives. Sprague (2005) suggests that when researchers identify with or are confident that they understand the participant’s experience, this may signify one’s own place of privilege that normalizes participant’s views. Based on this thinking I endeavoured to use critical reflexivity to openly acknowledge my narrow views that are constrained by my assumptions, beliefs, experiences, and sometimes contradictory selves.

Trustworthiness

A set of quality standards and protocols does not exist for narrative research (Reissman, 2008). “Narrative truths are always partial – committed and incomplete” (Reissman, 2008, p. 186). Within hermeneutics, the intention is to endeavor to understand meaning. My role as researcher was to attempt to understand the meaning making within the narratives or to “interpret the interpretations” (Reissman, 2008, p. 188). I remained close to the narratives but at the same time moved away by reflecting, contemplating, writing, and engaging in dialogue with my supervisor and the literature as a means understand participants’ storied experiences. Smythe et al. (2008) deny the notion that “certain procedures” are necessary for trust and suggest that “what matters is what has held the thinking of the researcher and in turn holds the thinking of the reader; what calls,

what provokes them to wonder” (p. 1393). In keeping with these ideas, I selected provocative stories, or rather, the stories that were beckoning to be told (Frank, 2012a). In keeping with a hermeneutic approach, possibilities for understanding were co-constructed together with the participant narratives through a dialectical or spiraling approach, moving between parts and the whole (Heidegger, 1927/2010). Richardson (1994) discusses validity using the metaphor of a crystal to illuminate the notion that understanding within research is only partial.

Crystals are the prisms that reflect externalities and refract within themselves, creating different colors, patterns, arrays, casting off in different directions. What we see depends upon our angle of repose. Not triangulation, crystallization. In postmodern mixed-genre texts, we have moved from plane geometry to light theory, where light can be both waves and particles. Crystallization, without losing structure, deconstructs traditional ideas of “validity” (we feel how there is no single truth, we see how texts validate themselves) and crystallization provides us with a deepened, complex, thoroughly partial understanding of the topic. Paradoxically, we know more and doubt what we know (p. 522).

In order to address issues of trustworthiness, I have endeavored to attend to Reissman’s (2008) criteria that include attention to coherence, persuasion and presentation. Riessman suggests lived experiences are often incoherent, however there exist “points where individual’s accounts converge thematically (creating a community of experience), and other points where they split apart” (p. 191). As such, I have included a combination of narratives that reveal a coming together of common stories along with a divergence of select stories that split apart from other unfolding narratives. I have intertwined the analysis/findings together to represent the unfolding interconnectedness

of participant narratives and theoretical perspectives that evokes a questioning and possibilities for readers. Participant narratives are framed within a particular moment in time within the COVID-19 pandemic reflecting the complexity that is at play in the storied space(s). Persuasiveness refers to the notion that the interpretations are convincing to the reader (Reissman, 2008). To attend to persuasiveness, I include several participant narratives to substantiate claims and to convince readers that the participants were “speaking for themselves” (Reissman, 2008, p. 191). When referring to presentation or usefulness of narrative research Reissman (2008) states, “Ultimately it is up to future communities of human scientists to evaluate the work as trustworthy – worthwhile to pursue as a line of inquiry and/or a springboard for future work” (p. 196). In other words, readers of this work will formulate their own interpretations and views of whether this work is worth referring to and passing on to others. It is my hope that others may pick up on some of what is presented and continue the dialogue.

Chapter Five: “The Wolf You Think You Know”

Findings/Analysis

This thesis is a call to nursing leaders to return to their deepest roots and to unearth their authentic *self*, the self that for some has been “relegated to the poorest land in our psyche” (Pinkola Estés, 1995, p. 1). Following Frank’s (2012a) dialogic nature of narrative methods, the findings are intertwined with the analysis to facilitate dialogue between the multiple voices of nursing leader participants, myself as both researcher and participant, my advisory committee, the literature, and other circulating voices that spoke to me throughout the time frame of this analysis. For Frank (2012a), dialogical analysis involves listening to multiple voices within a single speaker’s story. From a critical perspective, this includes attending to broader socio-cultural, historical, and political perspectives. Jackson and Massei (2018) suggest that forms of interpretivism limit thinking because of the emphasis on interpreting meaning within human experiences which they suggest negates other sources of “unthought data” such as field notes, social media, and news. I would argue that this may be true in certain understandings of interpretivism, however modern hermeneutic thinkers have evolved the practice of interpretation to include other textual, non-human voices or sources of data (Oksala, 2016). In the ensuing analysis, I co-read theory alongside other texts including the interview transcripts, media, news, conversations with nursing colleagues/acquaintances, and discussions with my advisory committee. According to Spivak (2014), reading and thinking with theory is “part of our mental furniture” (p. 77)

Dialogic analysis involves “putting the stories that are told into the conditions of the storyteller’s lives” (Frank, 2012a, p. 50). From my perspective, this means asking questions such as, “What conditions are shaping the narrative that the storyteller chooses

to tell?” “What are the possible hidden meanings behind the stories?” I could easily tell stories of the excellent collaboration, communication and planning nursing leaders shared. The long hours of work, and nursing leaders’ commitment to protecting the patients and staff. These *are* the stories of nursing leaders who participated in this research. I am truly grateful for nursing leaders who expertly navigated the constantly changing information, chaos, and unknowns within the early days of the COVID-19 pandemic. The motivation behind this research is not to call into question the knowledge, experience, or conscious intentions of nursing leaders, nor is it an attempt to discredit them, rather it represents an opportunity to unlearn and reimagine possibilities for nursing leadership practice.

In this chapter, the experience of phronesis within the COVID-19 pandemic is explored through a critical lens drawing on the work of Michel Foucault and Judith Butler, as well as critical leadership studies. The notion that phronesis is tied up with action denotes the importance of attention to underlying values and beliefs that one draws upon when making decisions and acting upon them. Frank (2004) states:

To act is to act on the basis of some value, and any value achieves specific meaning only in the unfolding of an action; actions alone enable us to know what the value means. In order to learn to act in ways that exemplify our values, we need to pay attention to how different actions develop, with what consequences, and for whom. In seeing how value-based actions plays out, we discover the goodness or failure of our action (p. 221).

Based on this thinking, I suggest that the discourse of managerialism has resulted in nursing leaders unconscious devaluing of nursing knowledge, thus concealing the nurse within the leader. For myself, and perhaps others, the ideas presented may be a

practice of consciousness raising whereby I interpret the historical and managerialist constructed roles of nursing leaders which have, for some, resulted in nurse leaders becoming subjects of hegemonic managerialist discourses. Within the complex bureaucratic and hegemonic structures of institutions, nurses and nursing leaders struggle to find agency (Traynor, 2019).

For Traynor, (1999) nursing leaders become acclimatized to the institution they work for. Geertz (1973) contends that human beings unconsciously “do things in certain ways” to become accepted and belong to a culture (p. 12). In order to survive in the wild, wolves must adapt to, and adopt the norms of their environment. Similarly, I contend that some nursing leaders adapt to and adopt the accepted norms and culture of work environments. Borrowing from Pinkola Estés, I have framed this narrative analysis discussion of nursing leaders’ experience of phronesis within the COVID-19 pandemic around the metaphor of the wolf and some of the stories from Pinkola Estés’ book. “Women who run with the wolves” illuminates the complexity of life lived and the stories within depict images of hegemony, subversion as well as powerful stories of agency and transcendence. Pinkola Estés (1995), refers to the inner psyche, or the inner soul of human beings which I see as one’s inner ontological perspectives and one’s authentic humanity which apply to all gendered human beings. I begin with the story of “The Wolf” followed by the threats to the wolf which consist of: COVID-19: A predator circling the pack; Chaos: “The wheels are falling off the bus”; Performance of nursing leaders; Leg traps and Vasalisa – Intuition and decision-making.

The Wolf

Wolves are pack animals who are relational and inquiring by nature. They possess great strength (Pinkola Estés, 1995, p. 2). The wolf is an “unusually intelligent, emotional

and sensitive” animal (Matthews, n.d., para 5). Wolves are highly adaptable, confident, and generous natural leaders. Like humans, no two wolves are alike, and they differ based on their genetic background, as well, their habitat or socio-cultural worlds (Matthews, n.d.). Contrary to popular beliefs, wolves are friendly animals who form strong social attachments. Their steadfast attachment to their own is why they are fiercely protective of their pack.

COVID-19: A Predator Circling the Pack

When COVID-19 began to surface in the province of Ontario, several nurse leader participants described how they watched its progress from a distance; continuing to carry on in their everydayness watching out of the corner of their eye the increasing numbers of cases in larger cities, cases edging closer to smaller cities and towns, “...*the virus is moving towards us...and we are all watching it come... like a severe storm, we were like, oh my god, it’s literally moving down the 401 [highway]*”. In anticipation of the arrival of the virus, a number of nurse leader participants described how they began to develop plans based on Ministry of Health and Public Health directives, while inner fears and concerns remained at the forefront. One nurse leader participant depicts the heaviness of fear when they state, “*There were lots of days, especially early on, because we’d seen what was happening in New York and other places and, quite frankly, it was terrifying*”.

The anticipation of the arrival of the virus and what that would mean for institutions appeared to be based on what was happening in other cities and countries around the world. Several cities and hospitals were being overwhelmed by COVID-19. Hospitals were running out of body bags and setting up refrigerated morgue trucks. These stories contributed to what many nurse leader participants described as escalating fear, anxiety, and panic. Frank (2012a) speaks of the importance of honouring chaos stories

and although he is referring to the chaos narrative of an ill person, I feel compelled to honour and thereby tell the chaos stories shared by nursing leaders. Within healthcare, chaos is not socially/clinically acceptable and for some nursing leaders the need to portray the opposite was projected. Some nursing leaders, like wolves respond to an impending crisis by rising up and becoming alert. Within situations of chaos or crisis, front-line staff often look to leadership for direction. Brockman et al., (2018) suggest that within chaos, the skills nursing leaders require to manage include competence, excellent communication, collaboration, transparency, agility, and visibility. Not surprisingly, these were the characteristics several nursing leader participants articulated as key. The uncertainty and complexity of the COVID-19 pandemic was frequently described as “overwhelming” with many unknowns; unknowns regarding the arrival of the virus, transmission and spread, safety of personal protective equipment and, protection of the vulnerable. These issues were under regular debate because information was changing daily. No wonder there was chaos and panic.

Chaos: The Wheels are Falling off the Bus

Ancient Egyptians believed that the first and most necessary ingredient in the universe was chaos. It could sweep you away, but it was also the place from which all things start anew. (Picoult, 2020, p. 117)

Collinson (2011) suggests within critical leadership studies, there exists a dialectic between leaders and followers and power and resistance. According to Foucault (1979), “Where there is power, there is resistance” (p. 95). The chaos that ensued in anticipation of the pandemic in health care institutions reveals anxiety and panic in anticipation of the arrival of the virus.

I think there was panic involved for sure. And I think it was the fear of the unknown. We had, I was saying before, there was requests going up to have walls constructed, walls taken down. And some of them were in my area and I was kind of like, who's made that decision? And the director of facilities was saying, we're going to go round to the Emerg and we're going to give you a quote for knocking that wall down. And I'm like, hang on a minute. How did that come about? Whose recommendation is that? Because I've got an accountability to the senior leadership team to say, this is the rationale, this is recommendation for moving forward. Not, we're going to get a quote and tomorrow the builders are going to come in to take a wall down, or put a wall up, or build three new negative pressure rooms...were feeling that at one point, we've lost all control of what was going on on a day-to-day basis... people would just make decisions in the moment on what they thought was the best thing to do, and the rest of the organisation didn't know. ...the Emerg is now going to do this and change their practice around infection control, or resuscitation, or just general patient care practice. But the floors wouldn't know that, ...And then the medicine nurses would be like, well, I don't know anything about this. When did we start doing this? And it just creates this feeling that the wheels are starting to fall off the bus.

Within this nursing leader excerpt, power and resistance are revealed as health care practitioners attempt to control their own and their patients' safety within structures of power. The “*wheels falling off the bus*”, or the loss of control in the above excerpt, portrays the leadership discourse that leaders feel compelled to be confident and in control (Brockman, 2018).

During the COVID-19 pandemic, a local leadership podcast series was created entitled “Leadership and Uncertainty” hosted by James Shelley (2020). The intent of the

podcast was to invite various leaders to engage in a dialogue about issues surrounding leadership in uncertain times. In one podcast, the panel of leaders discussed the question, “How does one enhance decision making within uncertain situations?” The panelists agreed that decision making in uncertain situations requires legitimacy and accountability and to acquire legitimacy and accountability leaders need to communicate with and engage the perspectives of those who are uncertain. “When there is no communication, people tend to fill in the gaps” (Shelley, 2020). This podcast panelist’s perspective of leadership in uncertainty resonated with the narrative of the participant story below. The nurse leader participant explained that the physicians were uncertain and “filled in the gaps” based on their personal knowledge and ideas or recommendations from colleagues in other countries. In the following, the nurse leader participant is the manager of the emergency department. The nurse leader participant explains how front-line physicians were taking advice from physician colleagues overseas and in the USA:

We’d heard one of the ED [Emergency Department] physicians that’s got a colleague that he used to work with who was working in New York, telling us how bad it was and the mistakes that they made. And how we [the emergency room staff team] should be doing this, this, and this based on their lessons learned. And they were still in the thick of that as well. They were still really in a messy situation. So, we were getting that information from physicians that really wanted to implement stuff that really wasn’t tried and tested, from a scientific perspective, but was really just going through recommendations from other people that had had that experience and were telling us, you need to do this... the physicians are going off a little rogue and influencing the staff to do changes in practice that they may not have been ... yesterday, that practice looked completely different.

The nurse leader explained that the physicians took it upon themselves to begin to make changes within the emergency department without seeking input/support or collaborating with others including the nurse leader/manager. The nursing leader described how physicians began to make practice changes based on what they had heard from colleagues in Florida and New York. This same nursing leader as above states:

The Emerg is now going to do this and change their practice around infection control, or resuscitation, or just general patient care practice. But the floors wouldn't know that, and that impacts the floors, and that transfer of accountability when it comes to nursing. And then the medicine nurses would be like, well, I don't know anything about this. When did we start doing this?

The changes had the potential to impact safe practice of nurses and other disciplines. In normal circumstances, changes in practice involve significant review and consultation with multiple disciplines, policy and procedure committees, and professional practice leaders. Changes to practice protocols without consultation with other key stakeholders potentially raises safe and ethical practice concerns. This story does not represent all physicians however, does substantiate the existence of a dominant biomedical culture. Not all physicians adhere to the biomedical discursive culture, however it is evident that some still do.

The crux of the problem is that physicians were going “*off a little rogue*” changing established interdisciplinary emergency room practice protocols without consulting other disciplines or following important practice change protocols and policies. For this particular nursing leader, it felt like the wheels were falling off the bus. They state:

I think there was panic involved for sure. And I think it was the fear of the unknown. We had, I was saying before, there was requests going up to have walls constructed, walls taken down. And some of them were in my area and I was kind of like, who's made that decision? And the director of facilities was saying, we're going to go round to the Emerg and we're going to give you a quote for knocking that wall down. And I'm like, hang on a minute. How did that come about? Whose recommendation is that? Because I've got an accountability to the senior leadership team to say, this is the rationale, this is recommendation for moving forward. Not, we're going to get a quote and tomorrow the builders are going to come in to take a wall down, or put a wall up, or build three new negative pressure rooms. But that was the kind of stuff that was happening. And I truly believe that ... well, I know that this is the case because there were leaders here that were saying that they were feeling that at one point, we've lost all control of what was going on on a day-to-day basis.

In this situation, the nurse leader was also the organizational manager of the entire department therefore it appears that the physician is undermining nursing and organizational leadership. Jefferson et al. (2014) explore the power dynamic inherent in the medical model and the hegemonic cultural belief that values physician's knowledge over all other forms of knowledge. The nursing manager/leader possesses knowledge regarding underlying organizational systems and communication channels. Within this example, some physicians made changes to complex established practices, without consulting with other disciplines implicated in the practice change (leaders/managers) undermining the nurse leader/manager's authority within the department. The Royal College of Physicians and Surgeons of Canada (2015) outline competencies for physicians and under the role of leader, physicians are to "engage with others to

contribute to a vision of a high-quality health care” and “contribute to the improvement of health care delivery teams”. The story reveals that within situations of chaos, practitioners’ default to the health care hierarchy and that professional competencies may often be interpreted through one’s own perspective. However, many everyday health care situations are chaotic and therefore raises questions regarding how and why health care institutional cultures continue to contribute to and reify the health care hierarchy. For Foucault, within the apparatus of institutions those who occupy specific positions of authority, such as physicians, control what is considered true or false (Foucault, 1977/1995).

Interestingly, another nurse leader participant spoke about how nurses were eager and willing to follow the leadership of physicians in their department, despite the existence of a department nursing leader. Foucault (2000) suggests that within institutions there exist ‘regimes of truth’ which are:

...the types of discourse it accepts and makes function as true; the mechanisms and instances that enable one to distinguish true and false statements; the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault, 2000, p. 131).

It seems that within the chaos of the pandemic, some health care practitioners defaulted to traditional regimes of truth where the physician is considered to be the “master of truth” (Foucault, 1972, p. 115). Foucault suggests hierarchized institutions create relations of power in the form of discourses that prescribe the way practitioners think and behave (Springer & Clinton, 2015). Discourse is “a group of statements which provide a language for talking about – a way of representing the knowledge about – a

particular topic at a particular historical moment...Discourse is about the production of knowledge through language” (Hall, 1997, p. 291). For Foucault who we are and who we understand ourselves to be are shaped by the contextual discourses that surround us (Springer & Clinton, 2015). Foucault sums this up by stating, “we are trapped in our own history” (p. 329). For Foucault (2001), the truth of oneself is located within one’s socio-cultural historical situatedness which shapes one’s knowledge, beliefs and social practices. Within health care institutions the belief that physicians are the masters of truth, despite physician competencies that state otherwise, appears to be deeply entrenched within health care institutional cultures.

Performance of Nursing Leaders

Wolves, like humans, perform various roles according to their status in the pack and to function in their culture. They are acting. They could just as easily shift from being a dominant wolf to a subordinate wolf and vice versa as conditions change and show all the traits associated with those roles. Keep in mind that a wolf's real personality is often hidden under the character of his or her social position. (Matthews, n.d., para 5)

Reissman (2008) posits a dialogic/performance lens within analysis that exposes the performance of narratives. Reissman (2008) states, “Stories don’t fall from the sky (or emerge from the innermost ‘self’; they are composed and received in contexts- interactional, historical, institutional, and discursive” (p. 105). Drawing on the work of Erving Goffman (1956) and the performance of identity, Reissman (2008) suggests researchers intentionally pay attention to, “who” a story is being told for and the context of the storyteller considering what participants are purposely saying in the interview to portray themselves a certain way. For Reissman (2008), research participants play a role that allows them to be articulate and perform with confidence and ease. The performative

nature of phronesis was revealed in nurse leader participant' stories where they exemplified intellectual and or organizational /experiential wisdom.

Butler (1999) introduced a theory of performativity based on the work of Nietzsche and Foucault. The notion of performance “suggests a dramatic and contingent structure of meaning” (Butler, 1999, p. 177). In other words, the role one enacts has already been written and these roles have been developed for the purpose of portraying an image. For Butler, performativity is a result of pressure to conform to norms to survive “in compulsory systems” (p. 178). The notion of survival in systems, or the culture of health care institutions, illuminates the need to perform certain roles that align with a managerialist culture. Performativity theory draws attention to the culturally constructed performance of identities revealing the processes, structures, and contexts that “bring into being certain realities” (Butler, 2010, p. 147).

There exist various forms of formal and informal nursing leader educational and training programs. Within nursing in Canada, mentoring is a form of informal and formal training (Hodgson & Scanlan, 2013). Within a mentoring relationship future nursing leaders learn to perform a role that they watch and tacitly learn, similar to an understudy actor in a theatre performance. Just as new nurses learn by observing experienced nurses in practice perform the intricacies of language and mannerisms, many practitioners learn to mimic or perform the role that is socially accepted to fit within the institutional culture (Butler, 1999). Within most nursing clinical settings, students watch and model the behaviour of experienced nurses (Felstead & Springett, 2016). Nurses in practice observe and adopt mannerisms that are similar to the institutional environment; adopting and learning the behaviours to fit into the environment (Traynor, 1999). Human beings often hide their inner self (often unconsciously) in favour of the, “phantasmatic” or rather, the

illusion of what is real (Butler, 2002, p. 179). For Butler, the reality is that one feels compelled to act or perform in ways that mask one's true inner self (p. 179). Within the data, nursing leaders were seen to perform their roles in different ways, some revealed inner thoughts/fears regarding COVID-19 centred around the loss of lives, while others raised their hackles and performed the role of confident and competent leaders. Pinkola Estés, (1995) describes the natural instinct of wolf pack leaders to respond to a predator by becoming larger by raising their hackles.

Chapter Six: “Protecting the Pack”

Performance of Nursing Leaders

Protecting the Pack and Raising their Hackles

In this research, raising one’s hackles is a metaphor to describe the protective response of nursing leaders to the potential threat of Covid-19 to patients and staff. One nursing leader participant states, *“What would my absolute worst day look like? I just needed to ground that. And early in this I decided my worst day would be if one of our staff members died of COVID”*. The very real fear expressed by many nursing leaders in this study was the thought of a loss of a front-line health professional. There was a strong sense of responsibility within all nursing leaders to, above all else, protect the front-line staff and patients. The self-doubt and burden of responsibility was evident within nursing leader stories and this was openly articulated:

There were lots of days, even around the bed plan, where you were worried. We say, we think this is our best bet, we think this is the best decision, but, yeah, to your point, are we making the right decision. I think our worst fear was an outbreak in our own environment that was going to lead to employees getting sick and then employees passing it on. And, that burden was heavy. That burden was heavy.

Throughout the nursing leader stories, a genuine fear for the safety of patients, staff, their families, and themselves was illuminated:

That was my own personal angst. From a fear level, I was probably at the same as everybody else, we don’t really know where it is. Everybody was afraid of everything. Needing to calm everybody down and keep everybody, like, whoa, it’s okay, and being outwardly calm about everything, was a challenge. And then the leadership visibility

piece, making sure that I did put scrubs on, the nursing scrubs, not the green scrubs, and masks, and go out to all the areas and talk to people...

The nursing leadership discourse encourages nursing leader visibility as a means to show support and stay connected to front-line nurses. In the excerpt above, this nursing leader describes the need to be visible and don the costume of the *nursing scrubs* to portray that ‘we are in this together’.

In response to a predator, a wolf uses eye contact and posture to demonstrate their confidence. They carry

their tails high and stand tall (Living with wolves, n.d.).

Managerialism: Carrying Their Tails High and Standing Tall

Since the early 1980s, managerialism has persisted as a dominant political ideology influencing health care institutions and the nursing profession (Duncan et al., 2014). Managerialism is based on ideologies that justify the use of managerial authoritative strategies (e.g., policies, decision-making tools, access to information and other power wielding resources) that establish and maintain hierarchal hegemonic structures (Klikauer, 2019). Within health care, it is suggested that managerialism is often considered superior to professional decision making (Jefferson et al., 2014). Nursing leaders who adopt a managerialist mindset prioritize discourses of efficiencies and directives over other forms of knowledge including nursing knowledge (Rankin & Campbell, 2006). Rankin and Campbell (2006) suggest many nurses value objective scientific knowledge and negate their own experiential and nursing knowledge. Nursing leaders and nurses are socialized, “taught, coached and persuaded that it is their professional duty to nurse the organization” (Rankin & Campbell, 2006, p. 172). In other words, nursing leaders at times, prioritize institutional policies and procedures over

nurses' ways of knowing (Carper, 1978; Chinn & Kramer, 2011). Fast and Rankin (2017) examined the discourses influencing nursing managers and one of their key findings is that nurse managers "subordinate what they know empirically, from their experience of being on their nursing units to the ruling relations of an abstracted, authorized, institutional knowledge" (p. 6). They suggest that nurse managers thinking and decision making is influenced by institutional goals that are often incongruent with their own (Fast & Rankin, 2017, p. 8). Darbyshire (2020) notes that the dominance of managerialist ideologies continues to exist and persist within senior nurse manager/leaders.

For Foucault, "the subject" is a term used to describe the notion that human beings are subjected to and shaped by structures of power. According to Springer and Clinton (2015), "Foucault argues that individuals are made into subjects by being subjected to control by, and dependence on others, all the while taking on identities consistent with what they understand themselves to be" (p. 90). Subjects are socially constructed through discourse. Foucault believes one's identity is constituted by historical and cultural discourse which include sources of power that influence the identity of human beings who become "bearers of its power/knowledge" (Hall, 2003, p 56). Through this lens, nursing leadership discourse has contributed to the formation of nursing leaders who are subjects of the norms of the institutional cultures in which they are immersed. The following nursing leader illuminates their subjectivity influenced by the institutional culture:

With that grounding of directives, expert opinion, ethical framework, I'm fairly confident of every decision that we made. So there is none of this oh should've, could've, would've, worry about, like no, we made this decision, this is the best evidence we had at the time. Certainly, using and seeking more information as we needed to, so consulting with

people but at the end of the day we needed to make decisions fairly quickly and that's the decisions that we made.

Within this excerpt, the managerialist discourse of “directives”, “expert opinion”, and “best evidence” underpins this leader’s sense of confidence, knowledge, and power when they state, “so that’s the decisions that we made”. For Foucault, power is not possessed but rather exercised and can be used to ‘produce’ reality. Within managerialist organizations, positional power shapes the culture. One nurse leader shares the following: *There are a lot of those decisions, and they are made because I made them. There is no documentation, but this is the way I like it, and so I’m going to make that decision. That is, I think, the risk in healthcare with leaders, is in every individual hospital in that, you get this potpourri of what is going on, because at this hospital, this leader likes A, B and C, and they push and enforce it, and that’s the way it is at that hospital. Does that make sense? You go to another hospital down the street, and their rules are completely different. And trust me, you hear about it when people work in two or three spots...but I also do it [decision-making] in a way that is engaging and lots of dialogue. It’s not just, oh, I want this, and ... I don’t want to sound like I am very autocratic. I’m not. But the ability to influence the culture in a way that it benefits the staff and the patients is probably the piece that I like about it.*

Shamir and Eliam (2005) note that authentic leaders narrate themselves through stories that verify the values and beliefs that are self-validating. In the above excerpt, the nursing leader articulates their values however, there is a contradiction between stated values and actions. The articulation of the self as “not autocratic” and as engaging in “lots of dialogue” is contradicted by the statement, “There are a lot of those decisions, and they are made because I made them”. The above excerpt exemplifies the *heroic* perspective of

this nursing leader which assumes that the leader's decision naturally coalesces with what followers want (Collinson, 2018). The articulated or narrated self is a carefully constructed and complex act "actively composed in relation to others" (Holstein & Gubrium, 2000, p. 124). For Holstein and Gubrium, stories of self are methodically constructed, mediated by the interplay of discourse, relational circumstances, and the choice of self/selves one chooses to perform.

The operation of knowledge, power, and phronesis within nursing leadership narratives, is to some extent, performative based on the meta-narrative of nursing leaders within health care institutions. Shaw (2010) argues that leadership development discourse endorses sameness rather than difference and alignment with "recognizable leadership qualities" (p. 94). The leadership models and frameworks within nursing include discourses of managerialism touting lists of behaviours that have become typologies for leadership identities. Holstein and Gubrium (2000) posit the construction of *the self* is based on social and discursive systems. Individuals continually construct and revise their identities in response to the socially acceptable norms that surround them. Based on this thinking, nursing leaders align with competencies that highlight managerialist discourses such as organizational management, systems thinking, and strategic alignment with organizational vision (McGill University, 2017). For Holstein and Gubrium (2000) the self is not constantly at the mercy of discourse and is instead "a practical project of everyday life" (p. 70). The self performs roles within institutions to elicit desired responses (Holstein & Gubrium, 2000). The following nursing leader excerpt exemplifies performing the role of being political:

Being political, which I don't think nurses are particularly good at, to be perfectly frank. I don't think I'm very good at it a lot of the time. But having some political influences

around you in order to get what you want is really important. ...I do want to have political savviness that helps me to get what I want and be successful.

This excerpt reveals the wielding of power in the form of political savviness as a means to subtly influence situations. Performance of power was revealed in the back door approach or the subtle means of swaying people through various approaches. Another nursing leader spoke of their desire to change the culture within the institution and to do this they had to choose the “right leaders” who held the same values, beliefs, and vision. Foucault suggests “the endlessly repeated play of dominations” has contributed to history repeating itself. Boler & Zembylas (2003) contend that within health care institutions, individuals tend to surround themselves with other likeminded individuals because human beings are uncomfortable with difference.

For Traynor (1999), the use of “manager’s language” reifies one’s personal position and influence over others. Several nursing leaders narrate themselves as “experienced” and “capable”. The articulation of the self reinforces one’s identity or belief in the self one desires to be (Mead, 1934). The following nursing leader narrative highlights the emphasis on managerialist discourse:

We had a pandemic incident management team in place but it wasn’t ramping up and it wasn’t ramping fast enough and we were talking in the executive team ... there is probably five of us ... of how we were going to do this work and how we were going to get going. I can’t believe it at the time but I just said I’m willing to take on the pandemic incident management team leader role. I’m very comfortable with incidences, leading incidences, so very comfortable in that space and I just said yes. I’m going to take this on, I can drive this forward and I did that...I have to say I’ve been a leader for a long time, probably over 20 years. I just put myself forward because I just really had the confidence that I knew

how to lead this, I know how to lead crisis. I'm very good at that and I just said yes, I can do this. And I think oh my god why did I do that but also I was thinking to myself if not now when? ...I've led for a long time. I've done a lot of work on self-awareness and I know what I'm good at and I know what I'm not good at. I know what I like and I know what I don't like and I just really felt at this point I had the leadership skills to step up into this. I was very confident in that. Why is that, because I've done this many times before, I've led instances very successfully. I know how to get things done, very strong in operations, you know, got a systems lens and I feel like I have the credibility to lead through a crisis. So early I said yes I'm going to get this going, very knowledgeable about methodology of incident management and how to form a team and get that going. Very confident in my abilities...

The articulated “I” in this leader’s narrative exemplifies the relation of the individual leader subject to managerialist norms. Butler (2005) states, “the ‘I’ has no story of its own that is not also the story of a relation – or set of relations – to a set of norms” (p. 8). The narrative is spoken in a way that is self-assuring. Through articulating one’s beliefs about the self, one self-affirms and exemplifies the “effects” of the managerialist discourse (Butler, 2005). The articulation of the “I” in this passage highlights the performance of a desired self. Mead (1934) speaks of the developing self as a project whereby individuals observe and imagine themselves playing various roles. Through the adoption of learning to enact various roles our ‘selves’ are constructed (Holstein & Gubrium, 2000). Butler describes Foucault’s ideas regarding how humans give an account of themselves. Human beings draw on a number of pre-conditioned representations of themselves or “faces” (Butler, 1997, p. 29). Within institutions, there exist regimes of truth (institutional discourses) that constitute the self in which one

becomes recognizable and legitimizes one's beliefs regarding who one is (Butler, 1997; Foucault, 2000).

Several participants spoke of "leadership command teams" which was a strategy used within the pandemic to bring together key leaders to plan and make decisions within institutions. The use of the term "command team" denotes a "power over" others based on a dominant military regime giving the impression of control, power, and authority. Falling prey to the discourse of the managerialist culture was evident in the nursing leader's stories as they spoke of the need for control. Jefferson et al. (2014) suggests the managerialist context and medical model influence and shape nursing leader's agency. They argue that managerialist practice has led to the de-legitimization of nursing leaders resulting in them becoming an "'outgroup' no longer prototypical of the profession" (p. 824). In a sense, nursing leaders' performance of power is an expression of identity. To reify themselves they performed in ways that made them visible as "leaders". For example, making an effort to be more "visible" by physically walking around to check in with front-line staff. For Holstein and Gubrium (2000), the self, "is not only something we are, but an object we actively construct and live by" (p. 10).

Being Visible or Showing Up?

For Goffman (1956), human beings put on personal "fronts" which are roles that are representative of a person's social status (p.13). One nursing leader refers to the importance of being visible as "that visibility piece". The notion of pieces denotes a separation of parts that are separate from the self, purposely chosen and put together to create various personal fronts.

Several nurse leader participants expressed the belief that they needed to be more visible during the pandemic. This thinking stems from the leadership discourse that

suggests visibility is important to a supportive culture (Bergstedt & Wei, 2020). One nursing leader states, “I have been out on the units talking with staff, talking to people about how we are doing”. There is a sense of performativity within being visible. Within much of the leadership literature and popular leadership frameworks, being visible is synonymous with being a good leader (Brown, 2018; Bergstedt & Wei, 2020). However, it may be that the visibility of leaders sometimes disrupts the flow of work or creates a tension within workspaces. My own experience, illustrates the tension and disruption of workflow as a result of the arrival of the nursing leader:

When I was a front-line nurse, I recall the thoughts and feelings I experienced when the leader arrived. I felt the need to stop what I was doing to attend to the needs of the leader. I assumed that the leader’s arrival meant they wanted something and so their needs took priority over the work I was immersed in. In my experience as a front-line nurse, I often questioned in my mind, “Why are you here? They must want or need something? Perhaps if I respond to their needs, they will then leave so I can return to my work”. In my experience, the leaders’ arrival often disrupted the flow within the workspace, the work I was focused on or in the midst of, the rhythm of the work I was immersed in. This is not to suggest that this is always the case, however based on the power differential that exists between front-line nurses and nursing leaders, as well as the fact that most nursing leaders are not a part of the natural flow of the workspace, the arrival of a person of power can be disruptive.

When nursing leaders “arrive” are they offering help? Answering questions and clarifying communication? Is their “unannounced” arrival interpreted as surveillance? I am not suggesting that being visible is not a positive sign of support. Boykin et al. (2021) highlight the importance of leadership visibility within the pandemic. These authors

found that the presence of nursing leaders creates a culture that embodies a circle of caring. For Boykin et al. (2021), chief nursing officers and clinical coordinators abandoned the meetings they were supposed to attend to help with administrative tasks on the floors so the nurses could attend to patients; nursing leaders spent hours listening to front-line nurses about their concerns about the new PPE policy; and asked front-line nurses what the hospital team leadership could do for them. However, I question the motivation behind being visible? Is being visible always helpful? Is it to help or is being visible a way to reify one's identity? One nursing leader states:

I am a visible leader; out of all the senior leaders I am probably the most visible leader. I like going out. I know how I learn and going and seeing is how I learn and getting pearls from the front-line... Certainly I'm reaching out to a lot of leaders to see how they're doing. What's been really important from our staff, I heard this over and over, how our leaders have been supportive of them and being very visible and being attentive, so if staff were having challenges or whatnot. Again we want to keep that going so I've been very visible.

Who's needs are leaders meeting when they are making themselves visible? Perhaps it is *how leaders show up* in workspaces that is important. To show up has a different meaning than being visible. To show up is about creating space to engage in meaningful conversations that are 'other focused' which means being open and authentically present, truth telling, defending, protecting (Birdsong, 2020). An intentional commitment to genuinely being there, not doing for, but holding space and being present to genuinely see and be with others (Birdsong, 2020)

When you benefit from the work others have done, especially when you – by nature of your identity or access to resources – hold more power and privilege

than they do, you have a responsibility to show up for them. That's the rule.

(Birdsong, 2020, p. 30)

Some nursing leaders spoke of being visible as a sign of support while others spoke of the need to keep everybody in check, write policies, and seek approval which is suggestive of modes of surveillance. Some nursing leaders were concerned about “everything being documented”, concerned about audits, investigations, and accountabilities. The managerialist talk reveals the hierarchized surveillance of nursing leaders and the implicit power that is interwoven within health care institutions. Fast and Rankin (2018) state nursing managers are “produced by and held to” accountability frameworks, technologies and other forms of management tools meant to improve efficiency (p. 3). These discourses have insidiously become the dominant form of knowledge that seems to underpin some nursing leader’s thinking and practice.

Through the lens of Foucault’s (1977/1995) theories of power, accountability devices such as audits and the normalization of these devices produce positive effects of power. For Foucault, power does not always repress, it also produces (Scheurich & McKenzie, 2005). The nursing leaders’ concern regarding compliance with the institutional accountability devices reveals the positive productive effect of power. Institutional accountabilities are often underpinned by government mandates and policies (Traynor, 2006). Together, these produce a complex matrix of multiplying forms of power that may oppress and “imprint the souls” of those within the matrix (Scheurich & McKenzie, 2005, p. 855). These techniques of power are not necessarily intentional however, for Foucault their influence runs deep, transforming the inner ontology of human beings and in this case, nursing leaders.

Socially constructed nursing leadership models and competency frameworks create alluring images of how to be a competent and effective nursing leader. Over the past few decades, nursing has come to value frameworks and competencies as a means to measure “exemplary” leadership practice. According to Butler (1999) regulatory bodies have been developed to organize the dis-organized and have become the status quo. “Coherence” with these regulatory bodies is “wished for, idealized” (p. 173). The following is my journal reflection after completing the first few interviews:

A few of the nursing leaders remind me of some of my past leaders who often appeared confident and had an answer (whether you wanted it or not). The following are statements from the nurse leader participants in this research: “I think... ” “I” “For me...” “I had a plan” “I have experience” I decided...” “I believe...” “I really felt...” “I know...” “I am a leader...” “I would say...” “I am a fairly good communicator” “I made the decisions I made...” “I’m ready to take this on” “I have a lot of relationships” “I really stepped in...” As I listened to the interviews, memories resurfaced of my past experiences as a front-line nurse. I recall feeling like every situation was about the nursing leader and that no matter what issue I had to discuss with them, it would always be “well this is what I would do”. After a while, I stopped going for advice and/or support.

According to Weedon (1987), “Language is the place where actual and possible forms of social organization and their likely social and political consequences are defined and contested. Yet it is also the place where our sense of ourselves, our subjectivity, is constructed (p. 21). For Foucault, language and actions are integrated within discourse (Hall, 2003). The language within the nurse leader participant narratives reveals the performance of managerialist discourses. Weedon (1987) states, “Language is not the

expression of unique individuality; it constructs the individual's subjectivity in ways which are socially specific" (p. 21). In other words, one's ontological perspective, or way of being and the language one uses may be seen as constructed based on the world one is immersed in. The articulated subjectivity of the nurse leaders' statements in the above excerpt reveals the socio-political and historical nature of nursing leadership within organizations in which they work. Some nursing leaders perform the role that reflects a confident, competent leader however, the human being that is a nurse seems to be suppressed. Pinkola Estés, (1995) suggests people who have lost their inner soul become vulnerable to falling prey to leg traps. For Pinkola Estés, we lose our inner psyche (our soul) "by becoming too involved with ego, by being too exacting, perfectionistic, or unnecessarily martyred, or driven by blind ambition" (p. 287).

Performance ⇔ Humility/Vulnerability

For Aristotle (trans, 2011), phronesis involves the ability to hit the mean between two vices. Vulnerability and humility are essential to wise leadership (Brown, 2018; Rooney & McKenna, 2007). Perhaps the ability to enact phronesis lies somewhere between being courageous and being humble. Humble leadership has been receiving increased attention within the organizational and business leadership literature (Caldwell et al., 2017; Schein & Schein, 2018). For Caldwell et al. (2017), humble leaders are comfortable with 'not knowing' and understand that vulnerability is a natural condition of continual personal growth and learning.

Brown (2016) defines vulnerability as:

Being willing to express the truth no matter what; the truth of who you are; the essence at your core of what you are feeling at any given moment. It's being able

to open your soul and let it flow so that other people can see their soul in yours.

(0:47)

For Brown (2018), “vulnerability is the emotion that we experience during times of uncertainty, risk, and emotional exposure” (p. 19). Managerialist ways of thinking tout accountability and efficiency which leaves limited space for vulnerability. Within Shelley’s (2020) leadership series entitled “Leadership in Uncertainty” the leaders revealed a sense of humility and vulnerability by asking themselves honest, deep, philosophical questions such as “How much do I know and how much do I not see about the present?”. These powerful questions reflect humility, vulnerability and reflexivity.

McAllister, (2020) explores leadership within the COVID-19 pandemic and suggests staying true to one’s leadership values is essential to navigating uncertainty. One nursing leader in this research articulated leadership values as follows:

Honesty, trust, fairness and transparency; So, this ability to be genuine and real with each other... to me, the whole idea of wisdom and leadership is you don’t relinquish your values, you don’t relinquish your principles when things get awkward or things get tough.

This nursing leader participant continues with observations about differing values during conversations with members of the interprofessional team. They observe the physicians as valuing treatment of symptoms; the physiotherapist valuing rehabilitation; and nurses as valuing relationships, however, this nursing leader frequently observes a dissonance between articulated principles and actions:

From my perspective people talk a lot about principles and they will come up with theories. You can come up with a theory base, you can come up with all kinds of different things and people get all excited about it and gung-ho and everything else. They’re like,

this is what you need to do, you need to do this, it's all a crock really. Honestly, it's leading by principles and the principles really don't change, the same kinds of things apply as what my mother taught me when I was four years old. Because I have worked in leadership and there is so much hypocrisy. They will go out and say how they are going to treat the staff and how they want the staff to treat the patients, blah, blah, blah, but then they will keep secrets from people. Principles like transparency, being honest, treating people with respect, it's good until it doesn't suit somebody's purpose... And then they put all of their principles and all of the theory and everything on the shelf and then they deal with people in a totally different way.

Within this excerpt, alignment of values and principles with actions is highlighted. Alignment of values with actions involves reflexivity and is a key dimension of phronesis (Bachmann et al., 2018). Reflexivity involves an interrogation of the self and one's socially constructed, socio-cultural and historical being in the world (Norton & Sliep, 2018). Being reflexive is an attunement with one's values and beliefs and resulting actions. An individual who possesses phronesis is reflexively aware of and continually examines their assumptions and pre-understandings (Jenkins et al., 2018). This denotes ontologic reflexivity, or the ability to critically question how one's values and beliefs are being enacted and if they align with one's actions (Norton & Sliep, 2018).

The same nursing leader reveals ontologic reflexivity, demonstrating a conscious awareness regarding the enactment of values of honesty and transparency by explicitly stating to their team:

...there are things that we have to do and change because of corporate initiatives and government mandates that we don't have a choice about. There are things that you will

have a choice about that you will have input into when we're making a change because we want people's opinions, we want people's feedback.

This leader further emphasized the importance of transparency and described clearly differentiating to team members the difference between decisions when staff genuinely have a choice, and when they don't. This leader endeavours to differentiate when upper leadership is genuinely seeking staff input, or if the decision has already been made regardless of staff input. This leader expressed valuing honesty and transparency and trying to align these principles with their actions. Leading by principles may seem to be wise, however Schwarz and Sharpe (2010) caution against allowing one's principles to become too fixed. Fixed principles may limit one's perceptiveness to seeing the nuances and contextual differences within situations and may blur one's ability to use good judgement (Schwartz & Sharpe, 2010). Can one's principled practice be too fixed? Haraway (2003) suggests knowledge is often partial which is the view that one's ability to know is often limited by one's socio-political, historical situatedness in the world. One's values, beliefs and principles are shaped by one's situatedness in the world. Ceci (2000) invites nurses to recognize knowing and knowledge as limited by one's situatedness in the world and encourages nurses to endeavour to look past boundaries to gain new ways of seeing and understanding.

A key component of humility is acknowledging one's personal limitations (Caldwell et al., 2017). Several nursing leaders talked about "not knowing" in various ways; not knowing the answer to questions; not knowing what was coming next; not knowing how to respond to uncertainty. One nursing leader exemplifies the expectation to know by stating, "...you know what healthcare is like. You better know the answer." Foucault (1972) emphasizes the possession of knowledge and knowing as discourses

which those in power believe are instrumental to who they are. For Ceci (2000), one's social and professional identity are inextricably linked to who we believe we are. What we know, our knowledge, is often connected to how we understand ourselves.

Acknowledging the limits of knowledge reveals a humbleness within nursing leaders. Jankelson (2013) suggests humility is an unconscious presence within someone who possesses practical wisdom. Jankelson states:

Peculiar to the nature of wisdom is a kind of humility such that reflection on one's own actions as 'wise' is a particularly 'unwise' position. Furthermore, should we be graced by the presence of wisdom, it should not linger in consciousness for more than a fleeting moment, and even that may be too long! Thus, we can invite wisdom without specifically teaching it; we can aspire to wisdom and yet must avoid naming its presence in our own actions. (p. 61)

In other words, those who possess phronesis, may not see it in themselves. One nursing leader shares their humble approach without naming it as wise:

I don't think I have had a unique idea in my life. We're always drawing from other sources, and I think that is what gives us the richness. So, I think COVID-19 presented us with opportunities to really draw on all of those resources.

In the interview, this nursing leader stated, "I am not sure I have a lot of practical wisdom" and emphasized that the wisdom behind managing COVID-19 within their institution was based on the collective wisdom of the group. For Grant (2021), there is value in not knowing and humility: "If we're certain that we know something, we have no reason to look for gaps and flaws in our knowledge – let alone fill or correct them" (p. 42). Similar to Benner's (2001) work regarding expert practice, Grant suggests people tend to believe experience is equivalent to expertise. Tussing (2018) suggests that nursing

leaders who are hesitant about being in a leadership role may be better leaders because they readily seek out other opinions when unsure and are open to learning by listening to front-line nurses. All nursing leaders interviewed, at times, revealed humility and vulnerability however the tendency to equate the enactment of phronesis with being confident and competent was predominant. For Rooney and McKenna (2007), allowing oneself to be humble is being able to know and express the truth of who you are and what you value.

The “Seven Grandfather Teachings” from the Anishinabek peoples tell us that one cannot have wisdom without love, respect, bravery, honesty, truth, and humility (Centennial College, 2018). The teacher of humility is the wolf. According to the Seven Grandfather’s when you meet a wolf, they will bow their head in a show of humbleness and respect (Pribele, 2012). For a wolf leader, all that they do is for the pack; for the greater good (Centennial College, 2018).

Chapter Seven: “Leg Traps”

Pandemic Pay

In the 19th century, farmers would lay traps around their land to catch and/or maim wolves to prevent them from killing their livestock. Pinkola Estés (1995) states leg traps “... lie just below the leafy green of the forest floor. Psychologically, the same is true of the greater world” (Pinkola Estés, 1995, p. 230).

In my view, leg traps represent the unexpected challenges for nursing leaders. There were three leg traps within this research related to pandemic pay, hegemony, and PPE. Temporary pandemic pay was initiated by the Government of Ontario to provide additional financial support to front-line staff. The purpose was to acknowledge and support front-line staff and keep them working to maintain safe staffing levels and attract prospective employees (Government of Ontario, 2021). One nursing leader felt the government had good intentions however, applying the eligibility criteria was not black and white, and there were staff that were in direct close contact with COVID-19 patients that did not meet the eligibility criteria. For example, in acute care institutions a number of key front-line staff were not considered eligible such as radiology technicians (who are in close contact with patients taking chest X-rays), as well as physiotherapists and occupational therapists.

Phronesis involves decision-making, and judgement however includes action. For Kemmis (2012) praxis is the action of practical wisdom. Kemmis and Smith (2008) state:

Praxis is a particular kind of action. It is action that is *morally-committed, and oriented and informed by traditions in the field*. It is the kind of action people are engaged in when they think about what their action will mean *in the world*. *Praxis* is what people do when they take into account all the circumstances and

exigencies that confront them at a particular moment and then, taking the broadest view they can of what it is *best* to do, they *act*. (p. 4; emphases in original).

One nurse leader exemplifies phronesis in their decision-making and action regarding pandemic pay. This nurse leader shares the example of a staff nurse educator who possesses specialist wound care training and was often called in to consult on skin care/wound prevention. This particular leader made the decision to authorize pandemic pay for various nurses regardless of whether they met the criteria or not. For Aristotle, making the right choice is underpinned by the notion of sympathy: “having sympathy in some matters is an equitable thing” (Aristotle, trans, 2011, p. 129). Jenkins et al. (2018) further explain, “when exercising judgement, the phronimos must be sympathetic (today we might say compassionate or empathetic) to those involved to appraise a situation and make a correct decision as to what is equitable” (p. 3). Phronesis involves action however, behind the action is intellectual, ethical, and moral work that at times, results in actions that break or ignore the rules in the interest of social justice.

Within the course of this research, I often engaged in dialogue with my research supervisor, who is in a leadership position. During one discussion, we talked about the “behind the scenes” leadership that often takes place yet is often not overtly shared. My research supervisor shared that in their experience, some decisions and actions take place ‘at the table’, while at other times leaders are “disturbing and annoying” behind the scenes to do what is best. One nurse leader participant, who works in a community agency, took a behind the scenes approach and made the decision to pay drivers extra even before pandemic pay was implemented. They state:

Our drivers were literally transporting people to and from the hospital that were known to have COVID. So we implemented pandemic pay for them long before...in fact, the

funds still have not flowed. They still haven't flowed the funds. ... We've been paying our drivers for six, eight weeks now already.

For Pitman (2012) a “hostile ground” replete with tensions exists in professional practice where the policies and rules that govern decision-making are often in conflict with a professional’s desire to do good. Foucault (2008) posits the notion of competition as a natural phenomenon within society. From a critical perspective “competition is a formal mechanism that allows inequalities to function in a way that is stimulating for the economy and effective in terms of allocating resources” (Oksala, 2016, p. 141). The government dictated who was allowed to receive pandemic pay and this regime of truth potentially undermines the moral actions of nursing leaders who in the end, must make the choices within grey areas.

Lack of Personal Protective Equipment

Several nurse leader participants told stories of the chaos and panic surrounding the lack of PPE. One nurse leader states:

We had days where we had like three days of level-two gowns supply, like three days of not much supply. What are we going to do when we run out of level-two gowns, like what are we going to do? We had to make a difficult decision that we were going to use a plastic gown which is like a step up from a garbage bag. It is a gown but it's not the gown we want but this is the best we have. There is no other best thing here. This is all we've got. So there was a lot of those type decisions. There was a lot of fear, because we didn't have enough masks at one point or there was a perception we didn't have enough. We always had a couple of cases stocked and somehow we kept getting more but people wanted to use their own masks from home. People bought masks ... American masks and

people wanted to bring them in but we absolutely do have to follow occupational health and safety guidelines. It can't be a free-for-all or whatever, it just cannot be.

During this time frame of the pandemic, hospitals and agencies were sounding the alarm that there was a limited supply of PPE. Some of the leaders interviewed for this research were concerned there was a possibility of running out of PPE however none reported that they ran out. Nursing leaders grappled with deciding the best course of action to take in situations where there was the potential of running out of PPE. To clarify, at this point in the pandemic, there was limited understanding of how COVID-19 was being spread. The evidence suggested that the virus was spread mostly by aerosol droplet and some evidence suggested the virus was able to survive on surfaces for varying lengths of time. The decision in most institutions was to limit the use of N95 masks to only those working in direct contact with people diagnosed with COVID-19. However, there was a sense of anxiety because information was changing almost daily. My nursing colleagues who were working in acute care institutions during this time were concerned about the unknowns. For example, it was taking up to a week to get COVID-19 test results back for patients. My nursing colleague/acquaintances were concerned that they could be caring for a patient that might have COVID-19 but not know it yet. Experts were still unsure about the period of communicability prior to symptoms. Lupton (2013) explores "risk" within society and states that today's world of constant change and the increasing emphasis on "risks" within health care has contributed to increasing uncertainty, anxiety, and fear. According to Lupton (2013), in a contemporary world, people have learned that it is the individual's responsibility to control exposure to risks therefore individual front-line nurses perhaps wanted some control regarding their PPE.

Phronesis was exemplified by one nursing leader who, when they found out the PPE supplies were being locked up, states:

You never lock a cupboard with PPE supplies. You never lock it because the first thing that's going to happen is, they're going to say, you locked the cupboard with PPE supplies. So, we learned, unlock the cupboard. Let them take what they feel they need because that's how you reassure them.

This nurse leader exemplifies perceptiveness and sympathetic judgement.

Aristotle (trans. 2011) suggest phronesis involves the ability to perceive situations being sympathetic to those involved. Perhaps this nursing leader has been on the other side of a locked cupboard at some point in their career and understands the implications of locking up supplies. What does a locked cupboard of supplies say to staff? “You can’t be trusted” “You are going to steal or hoard” “We know better than you”. The assumption that there will be a “free for all” is constituted in managerialist ideologies.

Birdsong (2020) discusses the focus in today’s world on getting, winning, and being right, amidst a fear-based sense of scarcity. Birdsong states:

It plays into our well-developed fear instincts, creating a real and imagined scarcity of resources, time, and money. This fear-based sense of scarcity pits us against one another. It also leaves us with a poorly developed sense of “enough,” both of the material and of love and care. Both surviving these divisions and perpetuating them is draining us of our emotional resilience, grounding, and breathing room. (p. 22)

Hegemony

The COVID-19 virus is seen as a predator within leadership narratives, threatening the wolf and their pack. Nursing leaders spoke of the importance of protecting the patients and the staff as top priorities. Predators also exist in the form of dominant structures and forces that threaten the nursing leader. Hegemony is the social, cultural, ideological influence or authority over individuals and/or groups (Gramsci, 1999). For Simon (1999), hegemony is a relation between groups whereby the one group possesses power over the other, not by force, but by position and power. Hegemony is a “process of moral and intellectual leadership” through which those with less power consent to their own domination (Mastroianni, 2017, para 2). Critical theorists such as Marx suggest there exist superstructures which, in my understanding, resemble the complex political, bureaucratic, government, economic systems within institutions and society (Crotty, 2003). Marx suggests that “those who hold economic hegemony are able to shape the perceptions and viewpoints of those who do not” (Crotty, 2003, p. 120). Gramsci emphasizes the influence of contextual and cultural hegemony (Crotty, 2003). For Gramsci, hegemony exists as a reality for most, accepted as the norm or the status quo (Mastroianni, 2017). Hegemony is dynamic and always changing to maintain the dominant structures of power and to counteract potential threats to the status quo (Mastroianni, 2017).

Nursing leader stories offer a picture of hegemony. One nursing leader shares the story of how the organization transformed the entrance to the emergency department to incorporate pre-screening of patients for COVID-19. Many assumed that emergencies were going to be swarmed with people with COVID-19. This institution decided to have two registered nurses (RNs) and security staffing this screening point. As the weeks went on the numbers of people coming to emergencies with COVID-19 turned out to be fewer

than anticipated. This particular nursing leader decided it was not a good use of experienced RNs to be sitting at a table asking people COVID-19 questions. Due to the public fear of going to emergency rooms, many people were avoiding emergency rooms and so at times, the RNs were sitting for an hour, not seeing anyone. This nursing leader realized they needed more RNs to be trained to work in the ICU or helping train newer nurses hired in anticipation of a COVID-19 surge. They wanted to move the RNs back into a nursing role and suggested personal support workers or security guards manage the screening. However, a physician within the emergency department strongly opposed this decision, arguing that the RNs, rather than other non-regulated staff, should remain at the entrance conducting the screening:

He [the physician] said to me that he would rather have those experienced RNs out there than replace them with PSWs or students actually in the Emerg caring for patients. But he was prepared to die on that hill...he was kind of like, yeah, but I'm a physician and I'm telling you that this is a nursing role. And he said, I'm prepared to take it to our chief of staff to make that ultimate decision.

The nursing leader stood their ground. In the end, the chief of staff sided with the physician and the two RNs remained in the role as initial screeners. Three weeks later as the numbers dwindled further, the two RNs were then replaced by security guards. For Foucault, knowledge is always a form of power, and “assumes an authority of truth” (Hall, 2003, p. 49). Within institutional hierarchies, the prioritization of biomedical knowledge encompasses a “regime of truth”, or rather, a belief that based on the higher level of academic training, the physician(s) possesses the highest and most valuable knowledge.

Another nursing leader participant shares the story of the need to “engage” physicians by allowing them to make decisions regarding the organizational flow within the emergency department. They state, *“I knew it wasn’t right, but to keep them [physicians] engaged and to keep them feeling safe, there was no harm in doing it”*.

Why does this nurse leader feel they have to keep the physicians engaged? The two stories exemplify the hegemonic relations that continue to exist between nurses and physicians. Nurses’ submissiveness and dependent behaviours on the medical profession has been discussed within the literature for decades (Bell, 2020; Matheson & Bobay, 2007; Roberts, 1983). Boler and Zembylas (2003) state that denial and, I would add appeasement, is often used by oppressed groups as a “sophisticated” screen to cover the ways in which groups allow power to continually oppress them (p. 114).

Khalili (2014) suggests the silos between health professionals have existed for decades and will continue to exist if professionals continue to work in parallel to one another prioritizing their own profession’s knowledge over others. The pandemic did, for some, break down the silos between disciplines and unite health care professionals in a common vulnerability. One nursing leader tells the story as follows:

One day, I was walking [down the hall] and the lead physician for respirology was coming down the hall. We met at this window that overlooks the Emergency department and it was a moment that I’ll never forget from the pandemic, because it was a conversation where I could tell he was just as concerned as I was. And, I think sometimes we forget that physicians ... We put them on a pedestal, you know, he’s the leader of our respirology, and we forget that they have their own fears and anxieties as well...the conversation we had that day at that window I’ll never forget. It was just an open, like, we were both being transparent about how we were feeling in the moment and we sort of

shared our own fears and anxieties. It was not a conversation I'd had with him in the past and not a conversation I necessarily thought I would have with him. But, it's interesting how being afraid at times and how being in something together, because he really was a huge part of our plan, allowed this vulnerability to show up and for us to just be vulnerable in that moment, with each other.

There are a number of interesting notions in this excerpt. There is the shared experience of vulnerability within the pandemic which brought different disciplines together as human beings. There is the romanticized vision of the physician as being on a pedestal. There is the thinking that this is an “unforgettable moment” that implies this is a rare occurrence. Why are shared moments of humanity uncommon? Why aren't shared moments of humanity the norm? Who claims the authority to decide when it is okay to be vulnerable? Why do health professionals mask their own humanity within professional relationships? Boler and Zembylas (2003) question “why individuals comply with hegemony, even when it is against their best interests” (p. 124)?

The invisibility of hegemony to nurses and nursing leaders reveals that hegemony continues to exist and prevail in health care (Boler & Zembylas, 2003). Boler and Zembylas (2003) call for a “critical ontology of one's self” as a way to interrogate what one has become. A critical ontology of the self involves reflexively questioning one's habits, relations of power, knowledge, norms, and ideologies that have formed one's view of the world and what is right and best. Within the literature surrounding phronesis, phronesis is often explored within professional practice (Kinsella & Pitman, 2012) and individual or organizational perspectives (Küpers & Pauleen, 2013). Perhaps there exist possibilities in thinking about phronesis as a way of being, an ontological perspective of nursing leaders. For Rooney and McKenna (2007), phronesis as a way of being has the

potential to enable nursing leaders to recognize ideologies in practice, placing them in perspective in order to make decisions that value human beings over organizational outcomes.

According to Aristotelian philosophy, wisdom is, by definition, a finely balanced, difficult and uncertain thing in itself, and it suggests that to wisely deal with difficult and uncertain aspects of life, we need to relax our modern urges to rely on rationality and to seek control. In other words, paradoxically, we might be more in control if we are prepared to accept less of it (Rooney & McKenna, 2007, p. 131).

Chapter Eight: “Vasalisa”

"The wolf is an animal of great wisdom to be revered as a spiritual guide" (Living with wolves, n.d.)

Throughout the early phases of the pandemic, nursing leaders learned to navigate within a constantly changing landscape. In the early months, nursing leaders were faced with new challenges that required them to make judgements and decisions, without a playbook, numerous times a day. Like wolves, the nursing leaders in this study often appeared to rely on intuition and instincts.

In thinking about intuition, I wish to share the tale of “Vasalisa the Wise” (Pinkola Estés, 1995). Vasalisa is an old Russian fairy tale that is a combination of “Cinderella” and “Hansel and Gretel” with a few interesting twists. The story is about a young girl named Vasalisa whose beloved mother dies and upon her deathbed gives Vasalisa a tiny doll that represents wisdom. While kneeling at her deathbed, Vasalisa’s mother tells her “Should you lose your way or be in need of help, ask this doll what to do. You will be assisted. Keep the doll with you always” (p. 77). Like most fairytales, there is a dark side. In this tale Vasalisa’s father remarries a wicked woman who has two equally wicked stepdaughters. Similar to Cinderella, the stepmother and her daughters dislike Vasalisa because she is sweet and kind, so they conspire a plan to get rid of her. Deep in the woods surrounding their home, lives an evil witch named BabaYaga. Baba Yaga is known to kill and eat children. However, the witch also has the ability to provide fire. The wicked stepmother and sisters purposely snuff out the fire in their home and tell Vasalisa that she must go into the woods to get fire from Baba Yaga. Vasalisa does not know who Baba Yaga is nor does she know how to find Baba Yaga, however she is worried for her family’s need of fire for light and to cook so she courageously strikes out

into the woods to find Baba Yaga. Afraid and alone, Vasalisa reaches into her pocket to consult the doll her mother gave her, and the doll tells Vasalisa which way to go in the woods to find Baba Yaga. Like most witches in fairy tales, Baba Yaga is evil and frightening. The witch creates several preposterous tasks Vasalisa must complete to earn fire. With the help of her doll, Vasalisa successfully completes the impossible tasks gaining the respect of Baba Yaga who rewards Vasalisa by sending her home with fire. The story of Vasalisa is about looking to one's inner wisdom to find one's way and the rewards of doing what is right. Thinking about and making decisions based on either scientific evidence or experience alone does not leave room to consider the uniqueness of situations and concern for human beings. "Phronesis is not a cognitive capacity that one has at one's disposal but is, rather, very closely bound up with the kind of person one is" (Dunne, 1993, p. 273).

Intuition and Decision-Making

In the early phases of the COVID-19 pandemic, nursing leaders' experiences are similar to the tale of Vasalisa who was sent into the woods to find fire, without knowing where to go. For many, there was a sense of uneasiness as they were suddenly facing new situations. Wandering through the woods, trying to figure out which way to go unearthed stories of decision-making where nursing leaders at times reached into their pockets to consult with their Vasalisa doll, or inner phronesis. As the virus was circling the pack, leaders in this study appeared to frequently take action to protect the vulnerable. The following nursing leader narrates the difficult decisions to send all volunteer's home.

I remember sitting in the board room looking at the provincial data that was coming through of who was most at risk...it started in the early days, sort of 55 and over, females! I remember thinking, oh my god, that's all of our volunteers! ...I just remember

literally scribing down things we need to do, shut down and end the volunteer service, shut down the gift shop... And then it was literally, what was the consequence of making this decision?...Our volunteers do everything from meeting, greeting, registering and, in some cases, taking samples to the lab, taking patients to and from everywhere!

Immediately after this meeting, this nursing leader walked directly to where volunteers were located in the institution and spoke to them face-to-face about the decision to immediately send them home. The leader had not heard if other hospitals were doing this and had not received a directive from the Ministry, however they followed their intuition. A few days later other hospitals were sending their volunteers home. This nursing leader exemplifies phronesis by making the decision to do what was best for the volunteers despite a clear protocol or procedure. I see phronesis as similar to reaching into one's pocket and consulting Vasalisa, one's inner nursing intuition.

For most nursing leaders, the enactment of phronesis involved consulting with, or collaborating with a "command team". One nursing leader shared a story regarding a change of practice in response to a "code" (i.e., cardiac arrest) in the emergency department:

"...people were so stressed, they weren't even thinking clearly. They were moving too fast. We had a lot of conversations about putting their safety ahead of any patient safety, which meant everybody putting on proper PPE and doing a check before you rush into a code. They live in a world right now where you drop everything, run in, heroic measures. We're like, no, you're all going to stop and you're going to take that extra time to make sure ... yeah, but the patient is going to ... yes, that's right, they are going to be worse off, but you guys will all be safe. That was a big, hard piece for a lot of people to do that. But within five days, I'm going to say, everybody was on board. They saw the value of

protecting self first, and then going after the patient's needs... Now, you had everybody ... so, minimally, four to five people, let's say, preferably four, putting all their PPE on, checking each other, moving that patient outside, and then starting.

The above decision was a directive that came from provincial leaders and then further operationalized in consultation with institutional leadership teams. For Aristotle, “the goal of phronesis is to aim to hit the mean through deliberation” (Aristotle, trans. 2011, p. 126). For Aristotle, deliberation involves researching and exploring in order to determine an end result that is fair and just. “Aristotle does not refer to the mean as it is defined today (the average), but rather the mean is the point somewhere between excess and deficiency which may be closer to one than the other and is relative to individuals and individual situations” (Jenkins et al., 2018, p. 2). In the above excerpt, the ability to hit the mean involved choosing between acting quickly to initiate lifesaving supports for a patient within a code, or potentially putting oneself, the patient, and others at risk. The leader envisioned the potential for virus transmission which could be potentially detrimental to staffing numbers. This is similar to the ethical dilemma of the trolley problem (Jarvis Thomson, 1976). The famous trolley problem depicts a trolley racing down a track. The trolley brakes have broken and the driver of trolley, Casey must make a decision. Up ahead the track splits into a “Y”, or two tracks. On the right side of the Y, there are five people tied down on the track. On the left side, there is one person tied down on the track. Casey can turn the train, killing one person; or he can allow the train to continue onwards, killing five people. This story illustrates the ethical dilemma of having to choose to save one life or many lives and the complexity of making ethical decisions. Within the COVID-19 pandemic, there were several ethical decisions that were made. “Those on the front-lines may feel as if they are being asked to dive in front of a

trolley to benefit those unable to get off the tracks. The invisible enemy may not be as conspicuous as a runaway train, but healthcare workers have witnessed its deadly threat firsthand” (Mitchell & Attipoe, 2020, para 9). For nursing leader participants, the runaway train could be seen as the unanticipated ethical situations that arose requiring quick decisions. Under normal circumstances, practice and institutional policy changes take weeks, or even months to implement however, within the pandemic, decisions were made quickly, implemented one day, and changed/revised again in the next day or two because of new incoming information. One nursing leader participant states,

Every day there was another update, or there was a change again. And it was kind of like having to, okay, so now we need to look at it [the policy] again, we need to go back to the PPE policy. It's Wednesday. We only just got if finished Monday.

Kemmis (2012) states, “Phronēsis, however, does not and cannot escape uncertainty” (p. 153). For Kemmis (2012) possessing phronesis does not mean one has the innate tendency to make the correct decision in every situation, however possessing phronesis is the attempt to make the best choice even when uncertain. Several nursing leaders spoke of feeling uncertain and not knowing the answer. One nursing leader participant states, “I have never in my life said ‘I don’t know’ so much”. Some nurse leaders expressed a sense of unease with decision-making amidst the pressure of time and the constant influx of new information:

I felt that I was second guessing myself a little bit. With all the over 20 years of working in healthcare, in a situation like that that's so new, you start to second guess yourself to the point where you think, am I even suitable to be doing this role anymore? So, what I found that we were doing, and I think it was one of the other people that was sat round the IMS table, they said about having a second sober look at something. Getting

somebody to just have a second sober look at something. And we now use that as a mantra here.

Taking a second sober look involved asking others to review and provide input regarding decisions. Taking a second sober look became ‘a mantra’ for this nurse leader and their colleagues during this uncertain time. One nurse leader participant states, “*And maybe that’s part of what practical wisdom is really all about too, is that you have the perhaps courage or confidence to say, you know what I’m okay, if I screw up tomorrow, I can change it*”.

Nursing leaders talked about difficult decision-making. Several acknowledged they were making decisions to the best of their ability, in the moment, with the information they had in front of them. One nursing leader describes phronesis within the pandemic as decisions “in motion”:

I think of practical wisdom, practice wisdom as moving. It’s not the sitting down and thinking about it. It’s the walking through the hallways figuring out as you go along. It’s like you’re on the move while you are deciding. You don’t have the luxury of having a lot of time to plan so you’re really dependent on ... those relationships have to be there already. That basic knowledge has to be there already. The recognition of where the resources are and what resources you can have competence in, that all has to be there already so that when you’re walking down the hallway two or three abreast, online it’s virtual but that sort of image. You’re walking down the hall and you’re figuring it out. And you make those decisions in the moment and then everybody spreads out and does their thing and they come back together again.

Reaching into one’s pocket and consulting Vasalisa, or one’s inner intuition was enacted in several ways. Nursing leaders often consulted with other leaders when making

decisions. At times, when the responsibility of the decision fell to one nursing leader they accepted the responsibility, recognizing that they were making the decision to the best of their ability. This is exemplified in the following nursing leader's decision to apply Ministry of Health and Long-Term Care guidelines regarding infection control to the units/floors where older adults were:

...how do we keep our staff safe? Now, how do we make sure that everything ... we have control around these four walls, that everyone is coming into work every day and we're protecting them? That was a big ... that was part of that decision. There was a lot of angst to do that early, and it was just one of those, honestly, gut feels of, no, kind of now is the right time... not obliged by the Ministry, but morally responsible, was to treat our complex care unit the same as long-term care guidelines. We don't fall under the Long-Term Care Home Acts at all, but recall that they were quite stringent, their rules, for how food service delivery, leaving their rooms, all of the infection control, visiting ... and so, we went ... they went on... I forget the date that they went live on, but we went live the very next day for all of our patients who are essentially awaiting long-term care, so our ALC population... We still, to this day, have that going on. People are asking now, should we let that up? I say, no, because long-term care hasn't yet, but we're not long-term care. It still feels like the right thing to do to protect them.

The nursing leader in the above excerpt displays a moral obligation toward the safety and protection of older adults that is revealed through a sense of embodiment or a “feel” regarding their decision and action. For Merleau-Ponty (1962) human beings experience and perceive the world through their bodies. Phronesis involves a special form of knowledge that encompasses “... embodied practical wisdom... involves sensing, perceiving, making choices, and realizing actions that display appropriate and creative

responses under challenging circumstances through bodily ways of engagement” (p. 24). Küpers (2013) suggests that attention to embodied forms of knowledge allows a deeper perception and understanding of situations. Paying attention to bodily responses allows one to not only think about situations and experiences, but “relate to” and “live through” experiences resulting in wise(er) judgments (Küpers, 2013, p. 24). Kinsella (2018) posits attention to embodied reasoning has the potential to deepen an understanding of professional practice knowledge. Attention to embodied forms of knowing within leadership practice affords the potential to unearth tacit knowledge and intuition within nursing leaders. The nursing leader deliberately paid attention to and drew on their embodied sensing and knowing to make the decision to protect the older adult patients. At this early stage within the pandemic, protecting the older adult population was a priority however at what cost? Early in the pandemic, the decision to stop visitors was made however, shortly after came the realization that vulnerable and disadvantaged people, such as older adults, benefit from the support of family (Hartigan et al., 2021). One leader described the opinions around the decision-making table. Many were opposed to allowing visitors back because of the “potential risk” to the family member, the patient, the patient in the next bed and the staff.

Nurse leaders described how the decision to allow visitors back was not an easy one as allowing visitors back in, involved coordination of numbers of visitors (screening, testing, PPE, controlled patient visiting). The tension for some, seemed to stem from the amount of work (time, resources, screening, coordination, and monitoring) involved in coordinating visitors compounded by individual fears and the perception of increased risk. The perception of risk is different from actual or real risk. The perception of a risk is based on one’s subjective judgement which is influenced by socio-political, historical,

and cultural contexts (Lupton, 2013). Within today's society, there is a tendency toward risk aversion which has largely developed in response to an increased emphasis on avoidance of risk stemming from institutional and government risk discourse (Lupton, 2013). At this time in the pandemic public health reassured institutions and society that PPE was effective in minimizing transfer of the COVID-19 virus. The decision to not allow visitors seemed to be based on the *perception of risk* versus the actual risk.

Phronesis involves the ability to ascertain the best course of action through deliberation and judgement. Deliberation involves reflexively unpacking one's own values, considering other's opinions, empirical information/evidence that is available to do what is right/best for human beings. Allowing patient visitors (in certain situations) would increase the risk of potentially exposing other patients and staff. However, with the correct PPE, screening, and control of spaces where visitors are allowed to physically be with their loved one, decreases the potential risk. Considering the other side of patients and families and the mental, emotional trauma of not being allowed to have a loved one by your side when in a vulnerable patient position is seen by some as outweighing the risk of the virus. At this point in the pandemic, the evidence was not clear regarding the exact ways the virus was spread, therefore this decision involved personal and experiential knowing. There was an intricate dance nursing leaders described between needing to hear practitioner voices, validate their concerns, while helping them to see the other side of the visitor equation (the vulnerability of patient and families). One nursing leaders shares how they reassured staff that the visitor situation would be continuously monitored and acknowledged that it would not be perfect nor easy. This nursing leader talks about how they explained the situation to staff:

This isn't going to be easy. I think this is going to be an ongoing struggle and pain process for awhile. But I think that we need to be able to justify to say that we're working on it and we're trying to make it better. And we've got a core group now that are working on this policy. And if we have to meet every week to revise it and make tweaks and communicate to staff, then that's what we have to do.

As I write this, I have witnessed in a very personal way the consequences of risk aversion affecting someone I love. I wonder if health practitioners truly understand or think about what it feels like to be a patient? A patient who is not allowed to have their loved one with them; a youth, an older adult with dementia, a person who is suicidal. Reflecting on the above nursing leader narrative, I noticed that the patient and their family are missing from the discussion. I recognize that this was a time when decisions needed to be made quickly and leaders had to prioritize what was best for large numbers of people, however, it seems, even in a pandemic, there are times when the rules/policies need to be reconsidered in light of changing circumstances and/or unforeseen consequences. Institutions that tout the mantra, “patient and family first” potentially can feel like a jail or place of punishment to some patients. Drawing on the work of Goffman (1956), Sakalys (2000), describes hospitals as “total institutions”. “In total institutions, individuals are deprived of possessions, social role and autonomy, subjected to alien daily routines and rules, and may experience violations of the self, including lack of privacy and direct physical defilement of the body” (Sakalys, 2000, p. 1471). It seems that once one enters a health care institution, one relinquishes personal power and autonomy. Families on the outside, are also powerless. The following is my experience during the pandemic:

Over the first year of the COVID-19 pandemic I have watched my mom slowly decline through the visitor's window and iPad. For the first part of the pandemic, I was not allowed to visit my mom who is in a long-term care home. My mom has Dementia. Before the pandemic began, my sisters and I visited her weekly and between the three of us, we made sure she walked with her walker every time we were there, we took her outside for fresh air or for longer walks (in a wheelchair) to other floors or the garden, we had lunch with her, we did her hair and makeup, and we talked. My mom has struggled with dysphasia, however she would jibber jabber away and sometimes I could tell what she was trying to say despite her misuse of words. One year later, my mom is now slumped in a wheelchair, unable to walk, unable to feed herself, is incontinent and her eyes have glazed over. This was my mom's third year in long-term care. Her decline this past year has been substantial as compared to the first two years. Might she have declined as quickly if it had not been a pandemic? I do not believe so. I do not blame the staff. I know they tried their best, despite the understaffing and stressful work environment. By the time I was able to become her essential caregiver she had already lost the ability to walk and feed herself. I am only allowed to visit in her room and cannot take her anywhere off the floor or outside. I hope this changes this summer and maybe I will see some sparkle return to her dull glazed eyes.

Hall et al. (2018) highlight the benefits of engagement with people and being outdoors for people with dementia. Condemning older adults to remain within the institution was a decision made to protect older adults however I often wonder, if my mom was given the choice, would she have chosen to risk catching the virus versus not seeing her daughters. Frank (1991) illuminates the other side of being a patient in his classic book, *At the Will of the Body*. Reading this book made me think about what

patients are required to give up as they enter the four walls of the health care institution. Our bodies, our choices, our personal power is often left at the door. We become “guests” who need to ask permission to go the washroom, to ask for a drink, to ask for a Kleenex for a runny nose. Within the COVID-19 pandemic, the fear of going to the hospital meant the increased potential of contracting the virus but for some, it was the fear of having to ‘go it alone’, to walk through the doors without *even one* support person. Many I know avoided seeking care because of this.

Frank (1991) suggests, health professionals do not have a part in the tragedy of living with the after-effects of the hospitalization experience. The domino effect of decisions made at higher levels of the institution sometimes have long-lasting and intimate personal repercussions on patients and their families. Leaders are often not thinking about the ripple effect on human beings lives outside of the institution when they make decisions. One nursing leader exemplifies this by stating:

Sometimes, I think we have swung way too far to accommodate the needs of patients and families. We are one of those sites...how do we make sure that ...we have control around these four walls...I liked that ability to put some control and wrap our arms around what actually happens in these buildings again.

The need for control reflects the managerialist discourse and hierarchal decision-making structure within health care institutions and the institutional-centred thinking of nursing leaders. As I began this research, I had envisioned nursing leaders talking about nurse’s knowledge, patient-centredness, and relationships. After a few interviews, I began to wonder, where is the nurse in the leader? Have those in leadership positions lost their nursing values and beliefs? Similar to Buck-McFadyen & MacDonnell (2017), I question whether nurse leaders have lost touch with what it means to be a nurse, or their nursing

ontology? The following nursing leader's response provides a refreshing perspective regarding visitors and patients:

I believe as a nursing profession we have failed the people we serve because we have not advocated for them to be able to be with their loved ones. And we've failed them, and we should have learned from SARS. I was also in a leadership position during SARS. I was a VP, nursing at that time for a homecare provider. We should have learned during SARS. What I draw the analogy at, when I did my PhD, I did a nursing history course. And part of that was visiting at SickKids. So, in SickKids in the old, old days, they did not allow parents to visit except once a week on a Sunday, a parent could come, I think, for an hour or something. My mother was a pneumonia patient at SickKids and remembers vividly, to the day she died at 85, crying because she could see her father through the glass, and they wouldn't let her see him. But there's eloquent things written about these practices that were so horrific. When my brother was dying in an ICU, the ICU nurses kicked me out and said, no, you have to go out, and wouldn't let me stay with him. So, I have personal angst over this. I don't understand why we wouldn't have said, there's a risk to you coming to be with your loved one. You sign a waiver that you're not going to hold us responsible if you get COVID. You wear all the PPE, but you can sit by your loved one's bedside and hold their hand. What is wrong with that? Who are we protecting? Who are we protecting? And it's too easy for practitioners to, oh, just get rid of those pesky visitors. It's too easy. That bothers me very, very much that we've done that. They also forbid us as an organisation ... well, that's a bit strong. In the hospital's lockdown, we have palliative care volunteers, or volunteers who go into their hospital's palliative care unit and provide the caring support one-to-one, go and get the water, and sit with them, all those loving, caring, wonderful things. So, no, we couldn't

do that. They still have patients in their PCU, but they didn't have the benefit of those volunteers anymore. And there were volunteers who wanted to do that. There's something wrong with the thinking in this regard. And who knows where we tackle it. Is it at the public health people? Is it at the government people? Is it at the administrative people? I don't know where we tackle it, but as nurses that we didn't rise up, that we didn't rise up and put headlines in the paper and say ... and get our associations to lobby, to me has been wrong. From a moral perspective, that's the one thing I feel strongly about our profession.

Picoult's main character (2020) in *The Book of Two Ways* states, "We don't make decisions. Decisions make us..." (p. 410). The notion that decisions make us denotes that the choices we make in life aren't necessarily right or wrong. In many situations, we never know if our decision was the best choice because we can't go back and replay how things might have turned out if we had made a different choice. The main character in this novel realizes how decisions she made shaped the direction of her life. This novel made me think about the wisdom one gains from life experiences and how sometimes, one wonders how one's life might have been different if one had made a different decision or choice. For Picoult, the choices we make contribute to who we are continually becoming. Boler and Zembylas (2003) state, "no one escapes internalizing dominant cultural values, even though these values take different forms in different individuals" (p. 115). Within institutional settings, nursing leaders are immersed in a culture that reifies managerialist ways of being which seem to be contributing to nursing leaders, at times, acting in unwise ways.

Authenticity: The Wolf You Know...or Think You Know

“The tracks we are all following are those of the wild and innate instinctual self” (Pinkola Estés, 1995, p. 5).

For Pinkola Estés, (1995), the notion of digging deep into one’s pocket to consult one’s Vasalisa doll refers to intuition which is “the “treasure” of a person’s psyche (p. 76). The inner self or one’s psyche is elusive and difficult to apprehend because of the embedded nature of one’s socio-cultural historical situatedness (Heidegger, 1927/2010). I suggest one’s inner self is similar to one’s “wildish nature”. For Pinkola Estés, the word “wild” represents “who [we] are and what [we] are about” (p. 7). Within the leadership stories there is a sense of performance: performance of knowledge, performance of confidence and control, whereby nursing leaders’ inner selves are hidden behind the performance. Does the nursing leader role require nurses who step into leadership positions forfeit their ability to be authentic? Why do some health care practitioners continue to reify the belief that they must ‘act’ the role of a detached, emotion-free professional? Why does the belief that one must act in accordance with managerialist ideologies persist? Butler and Foucault shed some light on these questions through their work describing subjects and subjectivity.

For Butler (1997), “individuals come to occupy the site of the subject” and this act of occupying is unconscious. Butler draws on Foucault, to show that power forms the subject and is what one seeks or is attracted to: “what we depend on for our existence and what we harbor and preserve in the beings that we are” (p. 2). Butler (1997) suggests “the attachment to subjection is produced through the workings of power” (p. 6). Butler explains the formation of the subject drawing on Althusser’s famous example of the police officer hailing an individual on the street and the immediate response of the individual to turn to the officer. The response of turning to face the authority of the law

signifies the subordination of the subject to an authoritarian voice. For Butler, “a subject is not only formed in subordination, but that subordination provides the subject’s continuing condition of possibility” (p. 8). Butler (1997) uses the example of how children form attachments with adults which is an early form of subjection to an authority figure, however the subjection is unconscious. Subjection to authority is desired but also denied in the subject. The act of denial enables the subject to desire agency. Within the formation of the subject, “one is dependent upon power for one’s very formation, that formation is impossible without dependency, and that the posture of the adult subject consists precisely in the denial and re-enactment of this dependency” (p. 9). The notion of the unconscious subjection to power and re-enactment of the subject position resonates with my thinking and analysis regarding nursing leaders’ accounts within dominant hierarchical institutions. In other words, managerialist discourse forms and validates one’s identity (Butler, 1997).

For Aristotle (trans., 2011), agency is the capacity for human beings to make choices. Individuals can make choices through a process of reflexively exploring the discursive and ideological forms of power that have formed the self (Butler, 1997). Applying this thinking to nursing leaders, nursing leaders are often subjects formed by the historical discourse within health care managerialist cultures however, there exist possibilities to resist through individual agency (Butler, 1997). Power acts on the subject and the ability of the subject to enact power accordingly stems from one’s agency. In my personal experience, I recall a turning point in my professional practice when I realized my subjectivity in relation to governmentality.

I was a public health nurse working full-time within a government mandated public health unit. The programs and services of the organization were based on government

mandated program guidelines. The programs I developed and implemented were linked to the mandated program guidelines and dictated what I could do or not do as a nurse. I had decided to pursue a master's degree because I knew something within me was not settled. In one of my courses, I recall a conversation we were having about critical perspectives. This is when I first heard the term "governmentality". I recall sitting in the classroom listening to classmates share stories of their own and client experiences with public health. They spoke about the coercive elements of public health that attempt to shape the behaviour of individuals. I was sure the professor was going to speak up and tell them their thinking was incorrect and that their critical comments were disrespectful of government institutions. However, much to my surprise, the professor agreed with them! I began to wonder why everyone did not think the way I did. Something was wrong. I had never thought of the work I did as a 'power over' others as a means of maintaining the status quo. I believed what governments instructed us to do was the highest form of truth and that we should all conform.

This disorienting experience enabled me to realize my identity and my beliefs were products of my unconscious subjection to the government mandated institution. Falk-Rafael (1998) suggests nurses suppress their nursing identities within work environments that de-value nursing knowledge. It took me some time, along with further reading, listening and a lot of deep reflection to fully grasp and begin to understand why my view of the world was skewed and how to reflexively unearth my values and beliefs. I had to let go of a part of my personal identity to re-construct and re-learn who I was and who I wanted to be. This involved a process of unlearning and becoming reflexively aware of my inner self and re-aligning thinking, behaviours, and actions. It was not an easy process and made me feel extremely uncomfortable and vulnerable. Reflexivity

involves a stepping outside of oneself and looking back to critically examine one's situatedness in the world and the "taken-for-granted rules, habits, and traditions" that have influenced the self (McCorquodale & Kinsella, 2015, p. 312)

This experience enabled me to step outside of myself and acknowledge the self that had been complacent in maintaining the status quo, remaining silent and cheering on hierarchies of power. Since I left public health practice and began teaching, I have been afforded the privilege to see the world of professional practice through different lenses, through less privileged worldviews. I continue to learn about myself through work with an organization that provides supports and services to sex workers. The people who volunteer, work, and access this agency have taught me about power, humility, trust, respect, human kindness, love, and authenticity. Tracy and Trethaway (2005) suggest that one way to begin to realize one's authentic self is to put oneself in situations that are uncomfortable, where one is not an expert. I still find myself, defaulting at times, to the status quo and have to catch myself. The experience of unlearning and reflexivity are continual processes that require intentional noticing, listening and difficult personal identity work.

Pinkola Estés, (1995) posits that as the forests, trees, and wildlife of our world have slowly disappeared, so has the wildish nature in all of us. Pinkola Estés, (1995) refers to the wildish nature of the woman. However, as I read her work, I think of the wildish nature as similar to one's authentic nursing self. For me, at one point in my career I de-valued nursing and had lost my inner nurse. When I returned to pursue graduate studies I reconnected with my inner soul, my inner nurse, and my wildish self. Oksala (2016) argues human beings can disentangle their ontological perspectives from the web of dominant structures that have shaped one's beliefs, albeit, with effort. The emphasis on

effort denotes reflexivity and a willingness to see and unlearn. However, the will to unlearn and realize there are different ways of seeing the world, for me required that I step outside of the institutional box and enter a different world. This was an isolating and unnerving experience. Within contemporary health care institutions and managerialist structures, reflexivity is under-valued (Rooney & McKenna, 2007). Leadership competencies and models highlight the importance of reflective practice and self-awareness, however the deeper notion of reflexivity is not often included or perhaps viewed as important to nursing leadership. Pinkola Estés, (1995) states:

The deepest work is usually the darkest. A brave woman, a wisening woman, will develop the poorest psychic land, for if she builds only on the best land of her psyche, she will have for a view the least of what she is. So do not be afraid to investigate the worst. It only guarantees increase of soul power through fresh insights and opportunities for re-visioning one's life anew. (p. 58)

Ontologic Reflexivity

Hermeneutic phenomenology explores the interpretive nature of existence and identity; of being and becoming. For Heidegger (1927/2010), within all human beings there exists an inner being of one's being, which he coined *Dasein*. *Dasein* is *prior to* and is formed by one's socio-political, cultural, and historical *being-in-the-world* (Heidegger, 1927/2010). For Heidegger, *Dasein* is directed toward the world in the mode of care. What one cares about, pays attention to, and prioritizes is influenced by the normative ideologies of surrounding contexts (Heidegger, 1927/2010). To be reflexive, one must seek to understand one's innermost values, beliefs, biases, judgements, prejudices (what one cares about), and realize how they influence one's view of the world and actions. In my reflection above, I realized that my nursing identity was defined by bureaucratic

government ideologies. By assimilating with the dominant ideologies, I had lost my nursing self. My worldview was upended as I realized, I was inauthentic.

For Ferrell (2017) nursing leaders believe being authentic is key to the essence of nursing leadership. “Nursing in-the-leader-world requires special attention to presenting oneself to others in a genuine display of the professionalism and values within nursing” (Ferrell, 2017, p. 103).

Heidegger posits two ways of being: *authentic* and *inauthentic* (p. 43). “And because Dasein is always essentially its possibility, it *can* “choose” itself in its being, it can win itself, it can lose itself, or it can never or only apparently win itself (Heidegger, 1927/2010, p. 42). Dreyfus (1991) further explains Heidegger’s thinking regarding authenticity as three choices. One can accept and assimilate the dominant ideologies; one can seemingly choose a social role (such as nursing leader) as one’s identity however still not owning up to or not acknowledging one’s true inner beliefs or, one can recognize one’s authentic self. “Heidegger calls choosing itself and owning up Dasein’s authentic way of being” (Dreyfus, 1991, p. 27). Within this research, it is my interpretation that many nursing leaders identify with the social role of leader. For Heidegger choosing a social role allows one to disown or cover up one’s true identity. Heidegger refers to this as “seeming” to win oneself, whereas choosing a social role is a disguise for being authentic (Dreyfus, 1991, p. 27).

Popular leadership theories in nursing such as transformational leadership tout the importance of individualistic traits such as self-reflection and being genuine (Cunliffe, 2009). However, I suggest that one can only partially adopt these traits if one has not examined themselves or engaged in what I have termed elsewhere, *ontologic reflexivity*.

Ontologic reflexivity involves thoughtfully considering one's values, beliefs, and experiences; interrogating one's experiences, the social practices, and taken-for-granted knowledges that influence one's ontological perspectives. Ontologic reflexivity involves critically questioning the self, forms of knowledge being privileged, and a consideration of how one's values and beliefs regarding knowledge are exemplified. (Jenkins et al., 2021, p. 6)

Ontologic reflexivity denotes an open-mindedness, an intentional awareness of the self, and congruence between values, beliefs, and actions (Jenkins et al., 2021). Phronesis is a way of being for nursing leaders that includes attention to open-mindedness. For Sellman (2011) open-mindedness is a requisite virtue of nurses that is inextricably linked to phronesis. "Learning to be open-minded requires learning to hold beliefs in an open-minded way" (p. 200). One nursing leader participant spoke of the re-organization of the emergency department led by the leadership team. The leadership team invited physicians to provide input into the re-organized mapping of beds and rooms. There was no mention of nurses being invited to provide input. If one values the discipline of nursing, then one would presumably value nursing knowledge and recognize the importance of nurse's input into the design of a workspace where nurses spend more time as compared to other disciplines. Ferrell (2017) explored the experiences and meanings of senior nurse leaders' professional identities. A key finding was the power of the nursing lens as a valuable tool for nursing leaders. For Ferrell, the nursing lens of nursing leaders is a "powerful convergence of their knowledge, experiences, intuition, and worldview" (p. 101).

One nursing leader participant shares how nursing knowledge was valued and exemplified through the creation of a "COVID Nursing Group". The purpose of the

group was to seek input from nurses regarding planning and decision making. The group consisted of front-line nurses and nursing leaders:

We met for the first little while two or three times a week to talk, these are the changes, what do you guys think about this, what's your input on this, go back and get feedback from your peers and bring it back.

Being authentic denotes the alignment of one's values and beliefs with one's actions. The inclusion of front-line nurses in decision-making about the work nurses do, demonstrates recognition of the value of nursing knowledge. Rankin and Campbell (2006) suggest that merely including nurses at decision making tables is not enough and simply invites them to become subjects of the managerialist discourse. They suggest the need to legitimize and prioritize nurse's experience and knowledge. Including nurses in the mapping out of the departments in which they work legitimizes and values "nurses knowing from their everyday/everynight involvement in the workplace" (Rankin & Campbell, 2006, p. 177).

Nursing leaders articulated the importance of ensuring they were 'walking the talk' by wearing the non-respirator masks or gowns to demonstrate their solidarity with the front-line nurses and the safety of the non-respirator mask versus the N-95 respirator mask. The nursing leader participant in the previous example advocated for full disclosure of the PPE available in the hospital by posting a chart on the staff portal/internal communication system so that all staff could see the availability of PPE throughout the organization. This leader stated they valued open communication and transparency, and that their action of sharing the availability of PPE within the hospital again, reveals their authenticity.

Avolio and Gardner's (2005) authentic leadership approach (discussed in Chapter One) has undergone several critiques (Ladkin & Spiller, 2013; Shaw, 2010). Shaw (2010) argues the ability to self-proclaim oneself to be authentic, is lacking authenticity. Shaw states, "By invoking this high moral ground, authentic leadership positions itself discursively as above reproach" (p.103). Ladkin and Spiller (2013) suggest that the problem with authentic leadership is that the self within the leader may often be a product of dominant hegemonic discourses. To be an authentic leader, one cannot focus on oneself as a single autonomous individual and must include socio-cultural historical contexts that have contributed to one's formation (Ladkin & Spiller, 2013). They suggest being authentic is being fluid where the self is recognized as continually influenced and shaped through relationships, contexts, and experiences. In other words, authentic leaders are engaged in a continual process of being and becoming. For Heidegger (1927/2010), an important component of human nature is to strive to be authentic. Being authentic, involves a reflexive awareness of one's situatedness in the world and a recognition of how one's situatedness shapes who one is as a human being and as a nurse.

Wolves and other highly social animals have and pass on what can be best described as culture. A family group can persevere for several generations, even decades, carrying knowledge and information through the years, from generation to generation. When we look at wolves, we are looking at tribes—extended families, each with its own homeland, history, knowledge, and indeed, culture (Living with Wolves, 2021).

Have nursing leaders lost connection with their nursing tribe or pack? Have they put their Vasalisa doll in their pocket and forgotten about it? Perhaps, some have by choice, or maybe some have never possessed a connection to nursing. One nursing leader states, "I'm going to come unstuck a bit here. I don't draw on nursing knowledge. I don't even

know what nursing knowledge is and I can't stand the nurse-nurse stuff and the art of nursing just drives me mental". Perhaps not all nursing leaders' value nursing knowledge. Tracy and Trethewey (2005) state that "individuals gravitate toward and turn away from particular jobs depending in part, on the extent to which they validate a "preferred organizational self" (Tracy & Trethewey, 2005, p. 169). A disconnection with nursing and gravitation to the nursing leadership role is for some, I suggest, an attraction to managerialism, which seems to denote a turning away from the core values, history, and "homeland" of nursing.

I believe there is an inseparable link between who we are and our ability to enact phronesis. For Dunne (1993), "Phronesis is not a cognitive capacity that one has at one's disposal but is, rather, very closely bound up with the kind of person one is" (p. 273). The ability to make good judgements about what is right and good requires knowing the self and being open minded to situations, considering individuals, contexts, and the broader picture through one's own interpersonal and often clouded lens. Holstein and Gubrium (2000) remind us that the self is fluid, incomplete, and continually being revised. In other words, the self is not solely defined by discourse and contexts. Through individual agency, one can choose different selves to enact in response to varying circumstances and contexts. For Aristotle, phronesis is associated with someone who possesses characteristics such as courage and honesty, however within virtuous individuals lies an understanding of the self; the self that is influenced and intertwined within a socio-cultural, political, historical, discursive, bureaucratic, and messy institutional environment (McKenna & Rooney, 2019). A disposition towards phronesis denotes ontologic reflexivity; an awareness of the self and what lies behind one's judgements, decisions, and actions.

“Vasalisa now carries the blaze of knowing; she has those fierce senses. She can hear, see, smell, and taste things out, and she has her Self” (Pinkola Estés, 1995, p. 113).

Chapter Nine: A Call to the Wolfpack

“We all begin with the question, ‘What am I, really? What is my work here?’”
(Pinkola Estés, 1995, p. 106).

Phronesis has not been a prominent focus within nursing and/or nursing leadership literature. Perhaps this is because of the elusive, tacit nature of phronesis and the difficulty articulating how it emerges in practice (Kinsella & Pitman, 2012). For Kinsella and Pitman (2012), “*Phronesis* cannot be reduced to propositions; it cannot be instrumentalized. We know it when we see it, yet to put it into words is a challenge” (p. 163). The experience of phronesis for nursing leaders in this study was sometimes clouded by chaos and uncertainty in the early phase of the pandemic. From my perspective, the ability of nursing leaders to discern the best course of action within this turbulent timeframe of the pandemic was challenging because most had little to no work experience within a pandemic, let alone a global pandemic. My research reveals that phronesis is sometimes intentional where nursing leaders engage in a process of deliberation with colleagues and/or other leaders to discern and choose a course of action. However, phronesis is also evoked unconsciously or intuitively within one’s inner self. Frank (2012b) states, “*Phronesis* comes into being but has no specific beginning; we evoke it” (p. 53). Within my research, nursing leaders evoked phronesis by drawing on experiential and personal knowledge and/or on the collective knowledge of leadership teams, or colleagues from other institutions. For some nursing leader participants, the enactment of phronesis was at times, intuitive or embodied and decisions and actions were made “*because I knew it was the right thing to do*”. The benefit of experience was illuminated within my research. One nurse leader participant had worked during the SARS pandemic and their narratives reveal phronesis as an authentic moral sense of what

was right. Drawing on their experience from SARS this particular nursing leader made the decision to pay the client/patient drivers pandemic pay even though the driver “role” was not on the list of staff eligible for pandemic pay. This same nursing leader recognized the importance of not locking the PPE supply cupboard. For Aristotle (trans, 2011), the ability to be a *phronimos* requires experience. Kemmis (2012) explains Aristotle’s meaning of experience, “The person who is ‘experienced’ learns a way to be open, sensitive, and responsive *in and to* new situations” (p. 156). It seems that the nurse leader participant who experienced SARS understood what it felt like to not have access to needed supplies revealing an embodied sense of *phronesis*. Their understanding of the moral right for nurses to be autonomous and have access to PPE outweighed their concern of running out of PPE. The nursing leader enacted *phronesis* and the ability to hit the mean between two potentially undesirable outcomes. *Phronesis* is an intellectual and a moral virtue that denotes choosing what is best for human beings, however, it does not “*guarantee* that the good will be done, for anyone, let alone everyone” (Kemmis, 2012, p. 153). A key tenet of *phronesis* is to think through situations and decisions in order to make the *best possible* decision, which at times may turn out to be wrong (Kemmis, 2012). Bender (2018) posits the question, “better for whom” which I suggest is an important question to make visible the implications of decisions (p. 7). Further research is needed regarding the embodied details of *phronesis* such as the feelings one experiences within uncertain situations and the embodied performance of actions (Shotter & Tsoukas, 2014).

Critical Perspective

For Kemmis (2012), *phronesis* encourages attention to intentionally looking for different ways of seeing situations:

Phronêsis consists, first, in a preparedness to understand a given situation in *different ways*, and not to accept immediately that the situation is what it appears to be. It is a preparedness to explore different *already-available ways of understanding a situation* when we are in a situation in which we must act (p. 155).

Kemmis (2012) highlights an important distinction regarding phronesis which is a “preparedness to explore different *already-available ways of understanding a situation*” which I suggest is the thinking through situations and intentionally considering different ways of looking, drawing on other perspectives, such as critical perspectives. The notion of critical is not intended to critique but to examine deeply held beliefs regarding professional practices considering unintended consequences of decisions and actions (Kincheloe & McLaren, 2005).

Nixon et al. (2017) suggest a critical perspective affords a consideration of unintended consequences of decisions which opens up new ways of thinking and understanding situations. In keeping with Foucauldian (1980) theorizing, I understand much of what directs the thinking and actions of nursing leaders within institutions as often dictated by institutional discourses such as policies and procedures. Policies and procedures are a discursive form of power/knowledge that institutions utilize to govern individuals by defining what patients, families, and staff can or cannot do. In my research, several nursing leader participants prioritized managerialist forms of knowledge when enacting phronesis. Morse and Warshawsky (2021) argue that drawing on managerialist leader competencies is important within a pandemic and the future of nursing leaders, however, I believe phronesis holds promise as an important ontological perspective underpinning the future of nursing and nursing leadership practice. This

research reveals the ripple effect of decisions, such as not allowing a support person into institutions during the early months of the pandemic. In the moment, the decision was based on the best interests of staff and patients, however there was little consideration of the long-lasting unintended consequences on patients, families, and communities. The COVID-19 pandemic has illuminated the interconnectedness of health care institutions to communities, therefore there exist possibilities to critically consider the ripple effects of institutional decisions that attends to broader health and social issues which is part of the nursing mandate (CNA, 2017).

Emerging from my research are different ways of thinking about leadership decision making and phronesis as a way of being a nursing leader. My assumption is that many nursing leaders have not been exposed to critical perspectives perhaps due to the dominance of managerial and organizational development theories that underpin some nursing leader professional development and graduate programs. As well, some nursing leaders may have completed graduate education in business management programs so may not have been exposed to critical theory. Cutcliffe and Cleary (2015) suggest critical approaches to nursing leadership research are needed that ask difficult questions and challenge the status quo. I concur and would add that critical approaches are needed to produce knowledge that can create the kinds of change to which the discipline of nursing aspires.

Phronesis: A Way of Being for Nurse Leaders

Jankelson (2013) suggests “Phrónêsis is a way of being and is inseparable from the kind of person one is” (p. 54). I question whether it is possible for phronesis to be considered a way of being or, ontological perspective when, as Foucault (1980) suggests we are all subjects within systems. Within health care institutions where managerialism is

the dominant culture, there exist possibilities to enact phronesis within everyday interactions by “*taking a second sober look*” at the implications of decisions and one’s ontological perspectives.

The intention of my research was to seek a deeper understanding of how phronesis is enacted, what phronesis looks like in practice, the nuances of decision making, and stories that exemplify the process of how nursing leaders ascertain the best decision (and for whom) in complex situations. Benner (2001) calls to nurses and nurse researchers to collect stories that are exemplars of the important aspects of nursing practice. I had hoped that a narrative approach would reveal stories of vulnerability and and this method somewhat achieved this intention. However, I have doubts and questions regarding my ability as a researcher to create a space that invites such vulnerability. I wonder if my expectations might be my own yearning for vulnerability and authenticity in nursing leaders. Maybe this is all there is? Perhaps some nursing leaders (and nurses), share their innermost struggles with a trusted partner, colleague, or only themselves. I question whether the research space is a space that can reveal a deeper understanding of phronesis. I believe there is potential however, perhaps only some nursing leaders possess the will to reflexively examine themselves. Reflexivity holds potential to unlock a deeper understanding of phronesis and the ability to articulate how it is enacted.

I believe there is a tacit or hidden nature to phronesis, which one cannot articulate. Several scholars suggest experience is an important aspect of phronesis (Cathcart and Greenspan, 2013; Kemmis, 2012). I contend that it may depend on one’s ability to unpack experiences in a way that results in unlearning and reshaping one’s perceptions and beliefs transcending ideological discursive systems. If one is drawing on experiences

from the everyday, taken-for-granted status quo, then this has the potential to reify one's embedded, uncontested, belief systems. Rooney and McKenna 2007) state:

According to Aristotelian philosophy, wisdom is, by definition, a finely balanced, difficult and uncertain thing in itself, and it suggests that to wisely deal with difficult and uncertain aspects of life, we need to relax our modern urges to rely on rationality and to seek control. In other words, paradoxically, we might be more in control if we are prepared to accept less of it. While this might be a wise way of engaging with the world, it is a way that will be hard for many to embrace. It requires faith, confidence, humility and courage; without these it is unworkable, and this too is part of the downside. People and groups lacking in these virtues will still make wisdom claims, to the detriment of humanity, but getting it right will require considerable determination and resolve that may be at odds with the values that shape management practice today. (p. 131)

Performativity

Within the COVID-19 pandemic, the ability to deliberate and act for what is right was, at times, complicated by outside contextual forces such as Ministry of Health directives; internal contextual forces such as anxiety and fear experienced by staff, patients, families; and powerful ideologies, discourses, and hierarchies. The nursing leader role in some institutions has been constructed by normative ideologies within the culture of both nursing leadership discourse and health care institutions which has created specific attributes and roles of nursing leaders. This research reveals the performative nature of phronesis through dominant managerialist ways of being and managerialist discourses such as "*command teams*". For some nursing leader participants, their understanding of phronesis was performed according to the constructed discursive

narrative of ‘nursing leader as manager’ versus ‘nursing leader as nurse’. For example, some nursing leaders referred to managerialist discourses to exemplify phronesis referring to the creation of administration systems, distribution and management of resources. A few nursing leaders expressed the need to be confident and competent as important activities of phronetic nursing leaders. Rudman, (2018) explains that discourses often come together around particular values and practices that are framed by dominant systems such as managerialist systems. In my view, nursing leader’s ontological perspectives are often shaped by managerialist discourses and ideologies that enlist nursing leaders to perform their role to align with the institutional and managerialist ideologies.

Experience is important within phronesis however, as Benner (2001) suggests, years of experience in practice does not make one an expert. Several nurse leader participants articulated an understanding of themselves, and their capabilities based on years of experience which reveals the assumption that experienced leaders have a better understanding of who they are, however, years of experience does not make one an expert of the self. I suggest that years of experience, may at times, result in a deeper entrenchment of one’s identity within the dominant culture. Heidegger’s (1927/2010) notion of authenticity was not, I believe an absolute. For Heidegger, human beings can endeavour to become authentic, however due to the fallible nature of human beings and the power of normative ideologies, it seems unlikely that one can achieve authenticity. For Ladkin and Spiller (2013) the authentic leadership discourse assumes the leader can easily choose to act in ways that are congruent with one’s inner self, yet the ability to know one’s true authentic self is problematic when leaders are immersed in complex socio-political, cultural contexts. Ladkin and Spiller (2013) suggest that “perhaps one’s

inauthentic possibilities or imperfections help to shine the light on the full potentialities of a particular leadership moment” (p. 5). Along these lines, this research calls for nursing leaders to reflexively consider the role(s) they perform and to question the convergence (or divergence) with one’s performed role and one’s values and beliefs. Is one performing a ideological role of a nursing leader? Ladkin and Spiller (2013) state, “leadership is a relational phenomenon” (p. 1). In other words, leadership is a role one enacts in various moments however is not something that someone necessarily *is*.

Performativity has the “ability to determine what constitutes ‘being’” (Jenkins and Finneman, 2018, p. 160). In other words, the way nursing leaders think, act, and perform delineates the role of nursing leader which other nurses, who wish to become a nursing leader, aspire to emulate. This is potentially problematic when the leader role nurses are emulating is often created from a managerialist ontology. I suggest future research is needed that critically examines the performance of roles and the congruency (or incongruency) between values, beliefs, and actions.

One’s Inner Vasalisa – Taking a Second Sober Look

My research reveals the dominance of the biomedical culture and the prioritization of managerialist forms of knowledge. Nursing leaders are caught within a web of competing forces, where they have become subjects to dominant managerialist contextual forces (Butler, 1999).

Butler (1999) posits “culturally intelligible grid[s]” to describe the normative frameworks within society that construct accepted norms of thinking and behaviours. Similarly, within health care institutions, managerialist ideologies represent a culturally intelligible grid that prescribes accepted norms shaping nursing leader thinking and behaviours (Hutchinson & Jackson, 2013). Managerialist ideologies have created, what Butler (1999)

describes as, “regulatory ideals” that force one’s inner ontological nature to seem inadequate (p. 173). For Butler (1999) one’s inner self becomes overthrown by the “fantastical” nature of forces produced by discourse (p. 172). Butler posits the concept of agency as the ability to confront the forces that act against the self and to recognize one’s subjection to power. For Butler (1999), reflexivity provides a form of recourse in establishing agency. Based on Butler’s thinking, I suggest that through repeated acts, behaviours, and approaches that challenge the prevailing norms, and align with phronetic ways of being, there exists the potential for new approaches to ways of being a nursing leader that prioritize nursing values and beliefs. This is not to suggest that nursing leaders are not considering nurses and nursing. Most nursing leaders in this research clearly articulated they valued the profession of nursing however, actions and decisions of some were incongruent with the values, beliefs, and/or mandate of nursing. In my view, “*taking a second sober look*” represents questioning the dominant institutional and contextual discourses and thinking twice about what is motivating one’s decisions. Throughout the process of this research, I wondered if the inner nurse or Vasalisa had become lost to some. I would argue that the foundation of nursing, the knowledge of nursing, and nursing values and beliefs need to be at the forefront of nursing leaders thinking and actions. Donohue-Porter (2014) state, “Without confidence in the focus of the discipline of nursing, the leader in a clinical setting can unwittingly bow to competing demands” (p. 331). Valuing managerialist ways of being over nursing perspectives is a concern because of the continual erosion of nursing within health care and the loss of the discipline’s core or unique identity (Buck-McFadyen & MacDonnell, 2017; McCarthy & Jones, 2019).

Within the pandemic the shortage of nurses highlights the government’s reluctance to invest more in nurses (Mitsui, 2021). This thesis is not about government

spending and the nursing shortage however, this work does highlight how some nursing leaders may unconsciously be a part of and endorse managerialist systems that devalue nurses. Thorne (2021) suggests nursing needs to (re)claim control of practice conditions and it is nursing leaders who are positioned to make this happen. Phronesis is recognizing and seeing what is right in front of us sometimes, and nursing leaders possess the power to influence and change the institutional structures and culture that are wearing nurses out.

Reflexivity

Reflexivity affords individuals with the potential to understand how socio-cultural, historical, and political systems shape one's values, beliefs, and worldview (McCorquodale & Kinsella, 2015). "Reflexivity goes beyond reflection to interrogate the very conditions under which knowledge claims are accepted and constructed, and it recognizes the sociality of that process" (Kinsella, 2012, p. 45). A consideration of what is "best" for others in situations requires reflexivity and a deeper understanding of what one, as the decision maker "cares" about and what knowledge/truth is prioritized when making choices/decisions (Heidegger, 1927/2010).

The nursing leader participant narratives, at times, advanced descriptions of confidence and autonomy by positioning the nurse leader working in the best interest of patients and staff. Many constructed themselves as experienced, confident, morally responsible leaders reproducing a performance of the 'ideal leader' within the pandemic with minimal acknowledgement, or perhaps awareness of, the powerful discourses that at times, contradict the values and beliefs of nurses and nursing. The act of storytelling strengthens participant's belief in their narrative and legitimizes decisions made out of an articulated commitment to patients and staff (Rudman, 2013). However, actions were not

always aligned with nursing values. If nursing leaders value nursing knowledge then one might expect to see front-line nurses invited to contribute to the re-organization of the departments where the majority of staff in the department *are* nurses. Creating “Nursing COVID Teams” is an example, described by one nursing leader participant, that values nursing. For Losty and Bailey (2021) a key learning from their research regarding leading within the COVID-19 pandemic was that nursing leaders realized it was important to involve nurses in decision-making about their own work. Nelson et al. (2021) highlight the incongruencies between COVID-19 policies and front-line nurses’ knowledge of patients and families. Engaging in reflexivity questions the norms of practice and has the potential to upend organizational practices where nurses, and the voices of front-line nurses are included, or excluded.

For Frank (2012b), “phronesis, as a quality of persons, can only be acquired by changing oneself” (p. 49). Reflexivity has the potential to urge one to step outside of oneself and look back in through a critical lens that brings into focus one’s situatedness, power, privilege, values, beliefs, biases, judgements, preferences, political and ideological beliefs (Berger, 2015; McCorquodale & Kinsella, 2015). It seems a bit concerning when leaders are “I” focused and not cognizant of the norms that have formed views of the self as leader. Phronesis requires humility, vulnerability and the courage to ask oneself, “How much do I know and how much do I not see about the present?”.

Herein lies the potential for reflexivity. Shifting to a reflexive view of oneself allows one to unlearn in order to re-learn. Nairn et al. (2019) suggest reflexivity affords a “robust methodology” for nurses to uncover incongruencies and prejudices between nursing values and actions, and to affect change in nursing. Seeing differently and realizing that the ‘truths’ of one’s world view are not in line with one’s values and beliefs

is often an unsettling and difficult learning process however, this truth work is potentially important work for nursing leaders. There is limited literature that explores reflexivity within nursing leader education, practice and/or professional development. Reflexivity has the potential to afford nursing leaders the ability to seek out different perspectives which can advance nursing leadership in new and different directions. Future research might question whether it is important to understand the wisdom of nursing leaders, or as Linderman et al. (2015) suggest, perhaps we need to understand the positionality of wise nursing leaders.

Norton and Sliep (2018) have developed a model that illustrates the process of critical reflexivity as moving through four loops. The model is centred around a dialogical space where one intentionally considers one's socio-cultural, historical, and political contexts deconstructing values, discourses, power, and identity. Norton and Sliep (2018) suggest using a narrative approach with the model to examine and make sense of lived experiences. The telling of personal and professional stories while questioning the influence of power and discourse results in a deeper understanding of how institutional contexts influence one's thinking and enable one to develop an understanding of how power and discourses influence one's identity and world view. This model of critical reflexivity affords possibilities for nursing leaders to unlearn and fosters a commitment to understanding differing views and a continual examination and transparency regarding what informs one's position and actions.

Storch et al. (2013) suggest nursing leaders need to critically question organizational policies and mandates that contradict nursing values and ethical nursing practice. Storch et al. (2013) recognize that a lack of organizational support for nursing leaders exists and suggest collaboration between academia and nursing leaders as one

way to augment the support nursing leaders need. Centering praxis within nursing leader professional development and leadership courses holds potential as a means to focus on the importance of reflexivity, attention to naming and knowing the culture of health care and a consideration of what one is prioritizing within the process of decision making.

As an educator, the potential for change also lies within the education of future nurses where greater attention to threading and reinforcing nursing knowledge, nursing ontological perspectives, and reflexivity throughout the curriculum is needed (Jenkins et al., 2021). Tengelin et al. (2020) examined nursing students' views regarding norms and the formation of nursing identity. Their findings reveal that students are blind to power, are learning to see norms as "uncontroversial tools to guide their practice" and, aren't grasping the value of being reflexive (p. 4). A greater emphasis on learning critical perspectives and incorporating activities that require recognizing and understanding the influence of norms within undergraduate nursing education might begin to build a generation of reflexive nurses and nursing leaders.

Knowing and Naming the Culture

What is our present? What is the future that we want? What are the possibilities for nursing leadership? "If we can know and name the culture we are working in then we can find ways to work in it" (S. DeLuca, personal communication, August 4, 2021). For example, one nursing leader spoke of the back door approach they used to achieve what was important. This nursing leader advanced their agenda by meeting with influential individuals outside of formal meetings to have open conversations and to strategically find ways around bureaucratic structures such as policies and procedures. A consideration of what nursing leaders 'know' (epistemology) and what exists (ontology) illuminates the

socio-political situatedness of nursing leaders and the culturally constituted practices that arise from surrounding contexts. The way some nursing leaders think about leadership is influenced by ideologies and stereotypes that have shaped what is constituted *as* leadership. Jefferson et al. (2014) call for research regarding the contextual dynamics that influence the enactment of leadership and the way in which leadership practice reifies the culture of the institution. Jenkins et al. (2021) explore the commodification of health care and the effects on nursing leader practice suggesting nursing leaders aim for practices underpinned by subversion and parrhesia. Drawing on Foucault (2001), parrhesia refers to a reflexive form of morally driven truth telling that involves authenticity of self and risk-taking. Subversion is learning to work alongside the corporate structures. Jenkins et al. (2021) discuss the ideological belief that in order to sit at economic decision-making tables within health care institutions, nursing leaders must be able to “learn to speak finance” (p. 5). These authors argue that even more importantly is that “nurse leaders learn to speak nursing to finance” (p. 5). Jenkins et al. (2021) appeal to nursing leaders to use their power to destabilize the current hegemonic norms that are eroding nursing. There is a dire need for continued research that critically examines the historical, hegemonic, and managerialist culture that continues to persist as a means to know, name and transform the current culture. I suggest one way to begin to make a cultural shift is for nursing leaders to step outside of institutions to seek opportunities to reconnect with nursing through nursing graduate programs that offer critical perspectives different from traditional manager/leadership programs.

Spence (2017) states, “doing robust hermeneutic research in health care requires a form of situated and contextually practical reasoning consistent with the Aristotelian notion of phronesis” (p. 841). Based on this thinking, the process of conducting this

research involved a “morally-committed”, reflexive process informed by a diaspora of experiential, personal, embodied, empirical, and ethical knowledge of all who contributed (Kemmis, 2012, p. 150).

This research reveals the limitations in the current views of nursing leadership and offers new ways of looking at nursing leadership that has implications for education and practice. My research offers exemplars and stories of phronesis that are potentially helpful to understand the nuances of phronesis within nursing leaders in practice both within a pandemic and within day-to-day uncertainties. My research leads me to believe that phronesis offers a way for nursing leaders to navigate in complex cultures which potentially shifts the emphasis away from the individual onto the systemic institutional structures that are contributing to a culture that is often unsupportive of nursing, nursing practice, nursing knowledge, and nursing leaders.

This research is a call to nursing leaders to remember and to (re)connect with what nursing is and what being a nurse first, and nursing leader second means. To question themselves and their performance(s). To attempt to connect with one’s deepest inner authentic self. Nursing leaders can embody agency through a critical understanding of the economical, sociopolitical and cultural contexts of health care institutions. Rooney et al. (2021) suggest there is a deeper learning from experience with phronesis that involves “deep lessons” and “living through” an experience that involves reflection on the experience and a deeper embodied sense of the experience (p. 182). Leading into the future, I suggest, requires attention to reflexivity, critical perspectives and phronesis as a way of being. This research is a call to my nursing wolfpack, to uphold the values, beliefs and knowledge of nursing and (re)create our own path.

You were always the wolf. If we follow the rules we've always followed, the game will remain the same. Old ways of thinking will never help us build a new world. Out with the old. In with the new. Welcome to the Wolfpack Way (Wambach, 2019, p. 14).

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Appendix A

Letter of Information and Consent

Project Title: Nurse leaders storied experiences of practical wisdom amidst the Covid-19 Pandemic

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Western University

Research Team: Dr. Sandra DeLuca, Principal Investigator, Faculties of Sciences & Education, Western University; Dr. Elizabeth Anne Kinsella, Researcher, Faculty of Health & Rehabilitation Sciences, Western University; Dr. Derek Sellman, Researcher, Faculty of Nursing, University of Alberta; Karen Jenkins, Researcher, Faculty of Health & Rehabilitation Sciences, Western University.

You are being invited to participate in this research study that will explore nursing leaders' practical wisdom within complex situations including the Covid-19 Pandemic because you are a nursing leader in Canada and are working (or have worked) within the Canadian health care system. Practical wisdom involves deliberation about situations and choosing a course of action that is best for human beings. Within practice and the Covid-19 Pandemic as a nursing leader you are experiencing situations where you must consider multiple competing priorities when making decisions. This study will ask you to story your experiences, exploring your thought processes and deliberation; how you approached the situation, how you perceived the situation, the possibilities and outcomes you considered or had to consider, your emotions, doubts, what was clear, what was unclear, your intentions, what you valued, what was salient, the information you acquired and the people you may have consulted to help with deliberation that led to what you felt, in the moment was a practically wise choice and course of action. The proposed research responds to the need for more research regarding decision-making within complex situations such as pandemics, however you will be invited to share stories of practical wisdom you feel are relevant. The findings have implications for a deeper understanding of how practical wisdom is enacted and what influences decisions nursing leaders make within a pandemic that may advance education, practice and theory.

What will I have to do if I choose to take part?

This study is being done as part of the requirements for a PhD program and the need to better understand the experience of practical wisdom within nursing leaders by investigating practice exemplars. It is expected that you will be in the study for one year and this may include 1-3 interviews that will take approximately 1-1.5 hours. As well, you will be invited (but not required) to participate in reading and responding to other participant narratives that may take approximately 1 -3 hours. This time commitment will be flexible and dependent on your schedule, interest and availability. Overall, we are aiming to include eight nursing leaders in this study.

This study is using narrative methods so if you agree to participate your storied experiences of practical wisdom will be audio-recorded. In keeping with narrative methods, throughout the course of the study, you will be asked to read and respond to your own and other participant stories, however all identifying information will have been removed. Depending on your availability, interviews will be conducted at a time that is convenient for you and preferably when you are not at work. Interviews will be conducted and audio-recorded using Zoom technology however should the physical distancing requirements change during the course of this research, interviews may be offered face-to-face however will comply with what the Ministry of Health guidelines are regarding physical distancing. The consent will be sent to you via a password protected email for signing and we would ask that you scan and return using a password protected email.

Are there any risks or discomforts?

There are no known or anticipated risks with participating in this study. The greatest anticipated inconvenience will be your time. Reflection on yourself and your practice may uncover embedded memories and experiences that may make evoke emotions and make you feel uncomfortable. If needed, information regarding counseling and support will be provided.

What are the benefits of taking part?

You may not personally benefit from participating in this study at all. You may potentially benefit by contributing to the nursing leadership and wisdom body of knowledge during a pandemic and the advancement of research and educational practices. Participation may provide you with an opportunity to reflect on yourself and your nursing practice that may afford opportunities to affirm your practice or perhaps to change or improve various aspects within your nursing and/or nursing leadership practice.

You have the right to withdraw from the study at any time prior to publication. If you decide to withdraw from the study, you have the right to request (e.g., by phone, in writing, etc.) withdrawal of information collected about you. If you wish to have your information removed please let the researcher know and your information will be destroyed from records. Once the study has been published we will not be able to withdraw your information.

What happens to the information?

With your permission, the interviews will be audio-recorded. What you say will be typed out (transcribed by a transcriptionist who will have signed a confidentiality/privacy agreement), and all names and identifying information will be removed and replaced with pseudonym names. Quotes will be included in publications and presentations however all names and any other identifying information (personal names, agency names) will be removed. Your name and organization will not be disclosed or linked to the data and your personal information (name/institution/contact information) will be separated from all research transcripts and will be stored in a separate location in a locked filing cabinet in a research designated area at Western University. Electronic data will be stored on a encrypted (password) protected USB for the duration of the research and when the research is complete all data will be saved and stored on secure server at Western University and will be retained for a minimum of 7 years. After 7 years, all data will be destroyed. The de-identified data will be stored on the encrypted USB. All data that includes any identifying information will be transferred, once transcription is complete, and stored on a secure server at Western University. Only de-identified data will be used for analysis and will be sent to participants for review through a password protected email. Participants will be asked to review and return to researchers via a password protected email and destroy/delete from their computer once they have reviewed. There is a risk of breach of privacy as audio recorded data and consents will need to be transported from interviews and to the transcriber however the researcher will make every effort to ensure that all data is kept on their person when being transferred and will transfer to encrypted USB immediately following interviews.

By consenting to participate in this study, you are agreeing that your data can be used beyond the purposes of this present study by either the current or other researchers. The findings will be disseminated through 2-3 publications in peer-reviewed journals in the areas of higher education, professional leadership and practice, nursing philosophy, and through local, national and international peer-reviewed conference presentations. Quotes from interviews will be included in publications and presentations however names and organizations and any other identifying information will be removed.

Will I be compensated?

You will be compensated for your participation in this study in the form of a \$20 gift card donated to a local non-profit organization of your choice. If you do not complete the entire study the gift card will still be donated. Parking expenses will also be reimbursed if required.

What are my rights as a participant in this study?

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. You do not waive any legal right by consenting to this study. We will give you any new information that may affect your decision to stay in the study.

Who do I contact if I have questions?

If you have any questions or wish additional information, you may contact: Dr. Sandra DeLuca or Karen Jenkins.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics (519) 661-3036, 1-844-720-9816, email: ethics@uwo.ca. This office oversees the ethical conduct of research studies and is not part of the study team. Everything that you discuss will be kept confidential.

Thank you,

Principal Investigator
Dr. Sandra DeLuca, RN, PhD
Arthur Labatt Family School of Nursing
Adjunct Associate Professor
Faculties of Health Sciences & Education
Western University

Researcher
Karen Jenkins, RN, PhD (Candidate)
Health & Rehabilitative Sciences
Western University

This letter is yours to keep for future reference.

Consent Form**Project Title: Exemplary Nurse Leaders Storied Experience of Practical Wisdom**

I have read the Letter of Information, have had the nature of the study explained to me and I agree to participate. All questions have been answered to my satisfaction.

I agree to be audio-recorded in this research.

YES **NO**

I consent to the use of personal, identifiable quotes obtained during the study in the dissemination of this research.

YES **NO**

I consent to the use of unidentified quotes obtained during the study in the dissemination of this research.

YES **NO**

Print Name of Participant

Signature

Date (DD-MMM- YYYY)

Person Obtaining Consent
Print Name

Signature

Date (DD-MMM- YYYY)

Appendix B

Ethics Approval



Date: 26 February 2020

To: Dr. Sandra DeLuca

Project ID: 114515

Study Title: Exemplary Nurse Leaders Storied Experiences of Practical Wisdom: An Investigation of Practice Knowledge

Application Type: HSREB Initial Application

Review Type: Delegated

Meeting Date / Full Board Reporting Date: 10/Mar/2020

Date Approval Issued: 26/Feb/2020

REB Approval Expiry Date: 26/Feb/2021

Dear Dr. Sandra DeLuca

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Email Study Completion	End of Study Letter	20/Feb/2020	2
Follow up Email SupportCounseling_21_02_2020	Interview Guide	21/Feb/2020	3
Interview Guide_14_02_2020	Interview Guide	14/Feb/2020	2
Letter of Information_Consent_February21_2020	Written Consent/Assent	21/Feb/2020	4
Proposal_StudyPlanFeb14_2020	Protocol	14/Feb/2020	2
Sample_Email_Recruitment_02_20	Email Script	20/Feb/2020	3
Sample_Telephone_Recruitment_02_20	Telephone Script	20/Feb/2020	3

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
References Rationale	References	14/Feb/2020	2

No deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Patricia Sargeant, Ethics Officer (ext. 85990) on behalf of Dr. Philip Jones, HSREB Vice-Chair

Appendix C

Interview Guide

Practical wisdom is both an intellectual and a moral virtue. Practical wisdom is often needed within practice situations where the answer/action isn't necessarily clear. It involves deliberation, judgement and thinking about what course of action to take considering, in the end what is best or right or just for all involved. However, the thinking behind how nursing leaders think about and use this form of wisdom in practice and amidst a pandemic is not well understood.

In your experience and/or recent experience amidst the Covid-19 pandemic, can you think of situations where you have had to deliberate/contemplate about what is best to do and tell me the story of how this situation played out; what you were thinking (the emotions you experienced), the steps you took, and perhaps what you did to help yourself make the choice that you did.

Other prompts

Did you look to others for help?

In this situation, what was most important to you as a nurse? As a leader? As a person?

For you, what made this choice so complex?

What other issues were going on that made this complex?

What knowledge did you draw on when you contemplated or made your decision?

(Personal, Experiential, Aesthetic, Internet, Books, Journals, EBP guidelines, colleagues, others, institutional policies/guidelines etc.)

What was the outcome? Were you okay with the outcome?

If you could do things over, how would you go about it differently?

What influenced you?

Appendix D

Glossary of Terms

Being-in-the-world – The way humans exist and are involved in their world. What we are and what the world is, are mutually interdependent so that there is no such thing as a world apart from our experiences (Heidegger, 1927/2010).

Dasein – The being of a human being. Dreyfus (1991) suggests “the best way to understand what Heidegger means by Dasein is to think of our term ‘human being’, which can refer to a way of being that is characteristic of all people or to a specific person – a human being” (p. 14).

Discourse - A group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment... Discourse is about the production of knowledge through language. But ...since all social practices entail *meaning*, and meanings shape and influence what we do – our conduct – all practices have a discursive aspect (Hall, 1997, p. 72).

Hegemony - Hegemony is the social, cultural, ideological influence or authority over individuals and/or groups (Gramsci, 1999). Hegemony is a relation between groups whereby the one group possesses power over the other, not by force, but by position and power (Simon, 1999).

Ontologic Perspectives – Ontological perspectives are intertwined with one's ontology or view of reality, and epistemology, or what one believes as the truth. What one cares about or values is influenced by one's ontological perspectives or one's historical socio-political and cultural contexts. Ontological perspectives denote situated efforts to discern ontology, recognizing the partiality of perspectives (Jenkins et al., 2021).

Ontologic Reflexivity – the ability to critically question how one's values and beliefs are being enacted and if they align with one's actions (Norton & Sliep, 2018).

Reflexivity - Reflexivity is an ongoing critical appraisal of self and others in action; understanding how thinking and actions are shaped by one's context, experiences and relationships to others (Norton & Sliep, 2018). Reflexivity involves thinking deeply about and critically questioning one's position(s) of power, values, beliefs, assumptions, judgements, and biases (Kinsella, 2012; McCorquodale & Kinsella, 2015).

Subjectivity - Discourse produces ‘subjects’ which are figures who personify the particular forms of knowledge which the discourse produces. Subjectivity is a form of power which makes individuals subjects. There are two meanings of the word “subject”: subject to someone else by control and dependence; and tied to one's own identity by a conscience or self-knowledge (Foucault, 1982).

Curriculum Vitae

Name: Karen Jenkins

Post-secondary Education and Degrees:

Masters in Health and Rehabilitation Sciences 2011
Health Professional Education, Western University

Honors, Bachelor of Science in Nursing 1991
Western University

Honours and Awards:

Honors, Bachelor of Science in Nursing 1991

Ontario Graduate Scholarship 2018-2020

Vice-Provost's Award for Excellence in Online Teaching
and Learning: Preceptor Education Program 2018
University of Western Ontario

Related Work Experience:

Fanshawe College, Full-time Faculty, School of Nursing 2012-present

Western University, Arthur-Labatt Family School of Nursing 2009-2012
Contract clinical instructor

Middlesex-London Health Unit, PHN, Student Education Coordinator 1992-2019
Full-time Public Health Nurse

Publications:

Jenkins, K., Moodie, S., & Kinsella, E. A. (2022). *Reflective practice*. In McCorquodale, L., Ferguson, K., Doralp, S., Jenkins, K., Moosa, T., Moodie, S., Smith, K., Relouw, H., Thambinathan, V., Glista, D., Connelly, D., Wilson, J., McQueen, K., Whitehead, J., Bossers, A., & Kinsella. Preceptor Education Program for health professionals and students. (3rd ed.) www.preceptor.ca. London, ON: Western University.

Jenkins, K., Ferguson, K., & McCorquodale, L. (2022). *Successfully managing conflict*. In McCorquodale, L., Ferguson, K., Doralp, S., Jenkins, K., Moosa, T., Moodie, S., Smith, K., Relouw, H., Thambinathan, V., Glista, D., Connelly, D., Wilson, J., McQueen, K., Whitehead, J., Bossers, A., & Kinsella. *Preceptor Education Program for health professionals and students*. (3rd ed.) www.preceptor.ca. London, ON: Western University.

McCorquodale, L., Ferguson, K., Doralp, S., Jenkins, K., Moosa, T., Moodie, S., Smith, K., Relouw, H., Thambinathan, V., Glista, D., Connelly, D., Wilson, J., McQueen, K., Whitehead, J., Bossers, A., & Kinsella, A. (2022). *Preceptor Education Program for health professionals and students*. (3rd ed.) www.preceptor.ca. London, ON: Western University.

Jenkins, K. Kinsella, E. A. & DeLuca, S. (2021). Being and becoming a nurse: Toward and ontological and reflexive turn in first-year nursing education. *Nursing Inquiry*, 28(4), 1-9. <https://doi.org/10.1111/nin.12420>

Hall, J., Donelle, L., Rudman, D., Baumann, J., Weaver, H., Jones, R., Moulton-Sauve, M., Jenkins, K., & Trudell, A. (2020). It is important for everyone as humans to feel important, right? Findings from a community-based participatory needs assessment with street-level sex workers. *Social Work in Public Health*, <https://doi.org/10.1080/19371918.2020.1733163>

Jenkins, K., Kinsella, E. A. & DeLuca, S. (2019). Perspectives on phronesis in professional nursing practice. *Nursing Philosophy*, 20(1), 1-8. <https://doi.org/10.1111/nup.12231>

Kinsella, E. A., Caty, M.E., Ng, S., Jenkins, K. (2012). Reflective practice for allied health: Theory and practice. In L. English (Ed.), *Health and Adult Learning*, (pp. 297-321). University of Toronto Press.