ENACTING NURSES' LEADERSHIP THROUGH A CRITICAL ACTION RESEARCH INITIATIVE

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Doctor of Business Administration

by

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I have achieved so much and yet have so much to learn. To all whom I have had the pleasure to cross paths with, I thank you for your impact on my lifelong learning. Obtaining a high school diploma was a significant achievement in my family. Then I donned my white nursing cap and experienced a sense of pride that I thought would be insurmountable. Now, years later, after further studies, and degrees, in nursing, mental health, and education I have the opportunity of obtaining a doctorate in business administration from the University of Liverpool.

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ABSTRACT

Background: In Alberta, Canada, groups of family physicians engage with the provincial health authority to form Primary Care Networks. A major objective of PCNs is transformation of family practice clinics to the Patient's Medical Home model. This model is built on a premise of strong leadership within the clinic typically provided by the family physician. Evidence of physician leadership is not consistently forthcoming. Towards this end I have explored how registered nurses enact leadership in the Patient's Medical Home without occupying a specified leadership position.

Aim of my Research: The aim of my research was to understand how nurses enact leadership in their respective Patient's Medical Home. Further, in my research, I endeavoured to understand how leadership could be enhanced within each nurses' unique context. Specifically, I explored (a) the impact of role identity on nursing leadership in the PMH; (b) the impact of physician-nurse power differentials on nursing leadership in the PMH; (c) the impact of unrecognized leadership potential on nursing leadership in the PMH; and (d) the impact of lack of agreement, among nurses, regarding the nursing leadership role in the PMH.

Design/Methodology/Approach: I used a critical action research approach to explore this unfolding situation. I chose a constructivist approach as it respects the practice-based, emergent understanding, and knowledge, of the nurses as they collectively and collaboratively explored leadership within their respective PMHs.

Findings: Nurses enact non-positional nursing leadership (NPNL) within their respective PMHs through the interaction of identity, power, social influence, competence, and dialogue. Each incidence of leadership is unique to the actors and the context in which the actors find themselves. I have conceptualized my findings regarding NPNL via a flower metaphor whereby identity, power, social influence, and competence form petals around the pistal (center) of dialogue. The flower of NPNL is nourished via lifelong learning which fosters critical reflection and reflexivity. As the flower of NPNL grows and becomes more robust petals of leaderful practice (collaborative, collective, concurrent, and compassionate) will emerge.

Implications: The complexity of leadership in the PMH requires us to look beyond current leadership models and training opportunities. The visual metaphor of the NPNL flower enables nurses, team members, employers, and policy makers to not only recognize the as yet untapped potential of NPNL, but also provides a mechanism to accelerate enactment of NPNL.

DECLARATION OF OWN WORK

I hereby declare that this thesis has not been, and will not be, submitted in part, or in whole, to another university for the award of any other degree.

Treena Klassen

TABLE OF CONTENTS

LIST OF ACRONYNMS

AAP	American Association of Pediatrics
CFPC	College of Family Physicians of Canada
LAP	Leadership-as-practice
LPP	Legitimate Peripheral Practice
NPNL	Non-positional Nursing Leadership
PMCH	Patient Centered Medical Home
PCN	Primary Care Network
PMH	Patient's Medical Home
RN	Registered Nurse
WHO	World Health Organization

DEFINITIONS

Primary Care: Entry point into the health system. Provides accessible, comprehensive, coordinated and person-centered care over time (Muldoon, et al., 2006).

Primary Care Network: Publicly funded, not-for-profit corporations, formed through a legal joint venture agreement between a group of family physicians and the health authority in Alberta, Canada.

Family Practice: Conceptually built around a social unit (the family) as opposed to either a specific patient population (i.e. adults, children, or women) organ system (i.e. otolaryngology or urology), or nature of an intervention (i.e. surgery) (American College of Physicians, n.d).

Patient's Medical Home: A vision, whereby every family practice in Canada offers the medical care that Canadians want – readily accessible, centered on the patients' needs, provided throughout every stage of life, and seamlessly integrated with other services in the health care system and the community (Canadian Medical Association, 2021).

LIST OF FIGURES AND TABLES

LIST OF APPENDICES

1 INTRODUCTION

In 2006, I started the not-for-profit corporation, Palliser Primary Care Network (PCN). PCNs are government funded organizations with funding based on participating physician patient panels that are determined through fee-for-service billings. The PCN operates as a distinct legal entity with a board of directors consisting of physicians, provincial health system administrators, and a public member. Initially the scope of my job was to engage physicians to participate in the PCN, which was a relatively unknown entity at the time of local inception. Additionally, I needed to facilitate physicians to engage in discussions with each other, and the health region. Finally, I was tasked with convincing physicians to allow a non-physician health care provider (primarily registered nurses) to work in their respective clinics.

The beginning of the PCN was a rocky road with physicians declining to join the PCN. Additionally, my nursing colleagues voiced confusion, and mistrust, about why I would (a) wish to work with physicians, (b) invest my time and talents in something that would obviously be a flash in the pan, and (c) take on the headache, and risk, associated with working outside of the acute care hierarchy. My leadership position had me in the awkward instance of needing physicians to join the PCN, for funding purposes, while trying to influence transformation of the physician owned and operated primary care teams and clinics. Further to this, I wanted physicians to allow a PCN educated, and employed, nurse to work within their respective clinics. Simultaneously, I needed to entice nurses out of the safety, and predictability, of the unionized

acute care environment to the non-unionized, unknown world of primary care / family practice nursing.

It never crossed my mind that I would not succeed in implementing the PCN; I simply had to figure out how. Upon reflection, I remember a significant question at the end of my interview for this position; the interview committee asked me if I had any questions I wanted to ask. I responded with the following "as this is a business position with little or no place for clinical opinion why would you be interested in a nurse with a significant background in psychiatry/mental health and counselling?" The committee laughed and said "you will primarily be working with physicians." Although the response was said in jest, I have thought of it often throughout my career as the executive director of a PCN. I have heavily relied upon my dialogic skills to influence power differentials, gain acceptance into the physician group without losing myself, and further I have used my mental health counselling, and adult education skills, to engage in informal, and subtle, leadership of the PCN towards sometimes opposing, incongruent or unclear ends.

Fifteen years later, the PCN is a relatively stable component of the health care system in Alberta. At the point of writing this thesis, there is approximately 100 percent family physician participation in the PCN, with approximately 65 PCN employed nurses working within 42 physician owned and operated clinics. My current role is executive director of the PCN. I am the highest ranking executive of the company. I am primarily responsible for making the major corporate decisions, managing the overall operations and resources of the company, acting as the

main point of communication between the board of directors and the corporate operations, and I am the public face of the company. Our involvement with physician clinics has crossed many boundaries within the clinics touching on policy and procedure, information technology, quality improvement, and optimizing clinical practice and patient experience. Government expectations of PCNs have become greater both in breadth and depth. One of the most significant changes within the last 5 years is the government objective to implement the Patient's Medical Home model (PMH) throughout PCN physician clinics.

Although we have had great success in integrating non-physician providers within the clinics, we have not achieved the level of success in PMH transformation which we would like to see. There are many facets to achieving PMH transformation. That said, it is recognized that leadership is a foundational requirement for transformation of traditional family practice clinics to the PMH model (The College of Family Physicians of Canada, 2019). There is an assumption made by the College of Family Physicians of Canada, and other physician-centric organizations, that this leadership is only available through a physician leader. Through my over 15 years of experience, I have noted that effective physician leadership is not always present in family practice clinics. My experience aligns with Howard et al. (2016), who recognized that PMH transformation relies on shifting mental models and reimagining roles, including how leadership occurs.

In my thesis I explore the possibility of primary care registered nurses engaging in non-positional leadership to support implementation of the PMH within the clinics in which they currently

work. In the remainder of this chapter, I will first describe the background to the problem and then explain the aim of my thesis and its structure.

BACKGROUND TO THE PROBLEM

There is worldwide recognition that the health burden of non-communicable diseases, including mental health, cardiovascular, respiratory, cancers and musculoskeletal disorders, is on the rise (John, et al., 2018). Caring for patients with multimorbidity has proven challenging in our current system where we have been heavily focused on scientific method as the primary means to engage in patient diagnosis, treatment, management, and wellbeing. (John et al., 2018; World Health Organization [WHO], 2008). Furthermore, the specialization of health care providers, coupled with narrowly focused disease control programmes, has increasingly fragmented care (Starfield, 2002). Traditional primary care models are resulting in decreased performance coupled with decreased quality (John et al., 2018). Unfortunately, Canada has not been insulated from the above noted health issues and is not meeting the health needs of Canadians (Eisen & Bjornberg, 2010). Furthermore, in this failure, Canada is incurring increased spending at approximately 6.8% annual increase, which is surpassing the growth in the economy and government revenues (Canadian Medical Association [CMA], 2019).

The Euro-Canada Health Consumer Index ranks Canada 25 of 34 countries and further shows Canada spending more than 31 other countries on health care (Eisen & Bjornberg, 2010). In spite of this spending Canada has not been successful in achieving the primary health care vision identified by the World Health Organization in the Declaration of Astana (WHO, 2018). Specifically, Canada has not had wide spread, sustainable success achieving primary health care

services that are high quality, safe, comprehensive, integrated, accessible, available and affordable (WHO & United Nations Children's Fund [UNICEF], 2020). Along with being focused on patient-specific needs, a robust health system must be provided by health professionals who are well-trained, skilled, motivated, and committed (WHO & UNICEF, 2020). The road to health systems that deliver better outcomes, enhanced efficiency, and improvement in quality of care, are anchored in a robust primary care system (WHO, 2019). It is clear that health systems, including the publically funded Canadian health system, must transform to achieve the required changes in primary care (CMA, 2019). Efforts towards primary care transformation are occurring throughout the system.

There is a flurry of activity among clinicians, government, and organizations searching for new models and processes to achieve primary care improvement (Janamian, et al., 2014). WHO (2008) is specific that the health system must provide a multidisciplinary team, close to the client, who serves a defined population, collaborates with social services and other sectors, and coordinates with hospitals, specialists, and community organizations. Of almost universal acceptance, the model considered to have the greatest promise to achieve the WHO identified system outcomes is that of the Patients Medical Home (PMH).

In 1967 the American Academy of Paediatrics (AAP) launched the concept of the medical home to describe the role of the primary care paediatric practice as the repository of medical records for chronically ill children (Arend et al., 2012; John et al., 2018). This concept was then expanded by the AAP to include primary care that is accessible, continuous, comprehensive, coordinated, family-centered, and culturally effective (Arend et al, 2012). In 1978 the WHO

outlined the scope of primary care to include access to care, continuity of care, comprehensiveness and integration of care, patient education and participation, team-based care and public policy that supports primary care. In 2008 the National Committee for Quality Assurance adopted eligibility criteria, including the above mentioned concepts, to recognize primary care practices as Patient Centered Medical Homes (Arend et al., 2012). Over the years this concept has been adapted in Canada as the Patient's Medical Home and most recently health providers have begun expending the concept into the Health Home. I use the term Patient's Medical Home (PMH) in my thesis to reflect the most common terminology in Canada. The College of Family Physicians of Canada (CFPC) (2019) defines the PMH as a vision whereby family physicians are emphasized as the key to providing timely, compassionate, and high-quality care. The PMH model promises broad health system improvements including better access to care, decreased emergency room visits, decreased hospitalizations, reduced primary and specialty care utilization, improved preventative care, improved management of chronic and complex disease care, improved condition specific quality of care, improved palliative care, decreased use of inappropriate medications, improved patient and staff satisfaction, and lowered system costs (Ewing, 2013; Gumback, 2013; Helfrich et al., 2014; Maeng et al., 2012; Olayiwola, et al., 2011; Rosland, 2018; Towards Optimized Practice - Alberta Doctors, 2017).

Supporting the objectives of the PMH, the Canadian government developed a Primary Health Care Transition Fund that contributed $800 million funding, between 2000 and 2006, to reform primary care in Canadian provinces and territories (Carter et al., 2016). The province of Alberta took advantage of this funding from 2002-2006 with a goal to identify and develop infrastructure to support primary health care (Government of Canada, 2019). This federal funding was the

springboard for the Alberta government funded Primary Care Networks (PCNs), which began in 2003 (Government of Alberta, 2019). PCNs are not-for-profit organizations whereby the government provides public funds to support the PCN, which is jointly owned by participating physicians and the provincial health authority.

PCNs initially focused on chronic disease management and the development of multidisciplinary teams. The current objectives of PCNs include accountable & effective governance, strong partnerships and transitions of care, addressing the health needs of the community and population, and implementation of the patient's medical home (Government of Alberta, 2019). Although a variety of projects and models, aimed towards transformation of the PMH, have been active, both within and outside PCNs, since 2002, achievement of primary care reform has been variable. There are pockets of success within some physician clinics; however, a reliable and predictable route through which to achieve reform remains elusive. These PMH implementation challenges are also being reported in the literature (Janamian et al., 2014). The Alberta experience is in alignment with the findings of Peek, et al. (2014). Through their literature review, they determined that integrating primary care can improve quality, patient experience, create efficiencies and save money. However, they also note that evidence does not show how to make the clinical, organizational, and professional changes necessary to accomplish and sustain integration (Peek, et al., 2014, p. 430).

Gill and Bagley (2013) offer some insight into primary care improvement stating that complete transformation to the PMH model requires attention to leadership, teamwork, communication and metrics. Efforts to define leadership are based on a philosophy of positivism whereby

leadership exists in a manner which can be scientifically verified. As my literature review demonstrates this scientific evidence has yet to be established. Cromp et al. (2015) focus on the team as fundamental for achievement of the PMH desired outcomes. They go on to state that this relational work requires shared goals, shared knowledge, and strong communication (Cromp et al., 2015). Clinical leadership is cited as critical to improving quality in several recent inquiries, commissions, and reports (Daly et al., 2014). The literature is replete with examples of leadership as a key enabler for this type of large system primary care transformation (Donahue et al., 2013; Homer & Baron, 2010; Wutzke, et al., 2016). Despite leadership being recognized as a key PMH implementation strategy, there remains a limited number of studies, of low and mediocre quality, that evaluate leadership-training in this area (Nieuwboer et al., 2019). Empirical support to guide implementation of effective leadership models in the broad healthcare system remains limited (Daly et al., 2014). Compounding this problem, there is a lack of leadership content in undergraduate curricula (Cassel & Wilkes, 2017; Ellner & Phillips, 2017). Consequently, universities have populated our PMH teams with health professionals who are ill prepared to take on formal, and informal, leadership roles (Daly et al., 2014).

In summary the evidence is persuasive that leadership is required for PMH transformation; however, there is limited research demonstrating how to develop, and implement, the required leadership (Nieuwboer et al., 2019). Additionally, current evidence is limited and primarily focused on physicians. A search of the University of Liverpool online library yielded 25 results using the terms PCMH, leadership and nursing. The same search replacing the word nursing with physician yielded 139 results.

DEVELOPMENT OF THE PROBLEM AND RESEARCH AIMS

Although health, and more specifically primary care, has recognized, and made the call to action for increased leadership, it has been much less explicit regarding what the leadership should look like in practice and therefore how it would be increased (McMullen et al., 2013; Cleary et al., 2018). Supporting the argument for increased leadership some researchers are emphatic that a lack of leadership will impair development of teamwork, which is a core feature of the PMH (Hall & Weaver, 2001). Extensive literature about leadership is available. The available literature reduces as the literature review narrows to healthcare, followed by primary care, followed by the PMH, followed by nursing. I have used evidence from both non-healthcare, and healthcare, leadership literature to explore my problem. However, it is important to keep in mind the complexity of healthcare leadership including institutional, hierarchical, and gender bias embeddedness. These issues are combined with a fast-paced environment looking to be innovative, affordable, efficacious, and provide a consistent high quality of outcome and experience. I have considered literature from the global healthcare setting; however, the vast majority of research regarding the PMH comes from Canada and the United States. The concept of the PMH is recently emerging in other countries such as Australia making this topic meaningful from an international perspective (Metusela et al., 2020).

In their assessment of 16 small primary care practices, Gallagher et al. (2010) found that PMH transformation is more likely where co-leaders (physician and non-physician) are empowered to work synergistically. Similarly, Stout et al. (2017), in their survey of all staff at 12 primary care sites, found a strong association between effective leadership and practice teamwork perceptions in PMH transformation. In an attempt to link not only the need for increased leadership, but how

to increase it, the National Demonstration Project, which considered a diverse sample of 36 family practices over a 2-year intervention, recommended that PMH transformation requires physician leaders engaging in inclusive leadership (Crabtree et al., 2010; Howard et al., 2012). Eubank et al. (2012) make the argument for teaching family medicine residents what they describe as adaptive leadership, stating that PMH implementation requires leadership aimed at transformative learning and sense-making. Homer and Baron (2010) state that leadership is a critical success factor for PMH implementation and must articulate a vision, build relationships, and manage resources. Nutting, et al. (2012), in their 15 years of research focused on improving primary care practices, found that PMH structures and processes, within small primary care practices, need to include reflective sensemaking such that people are able to give meaning to their experiences, improvise in the practice, and engage in continuous organizational learning.

This introduction to the PMH leadership literature demonstrates the current focus on physician leadership. This physician centric view is an outcome of the PMH model primarily being a product of physician organization(s) with minimal input from the broader health system (Crabtree et al., 2010). An exception was found with Homer and Baron (2010) who indicated that spread of PMH will require engagement of nursing and further questioned if PMH leadership must be provided by a physician.

The Canadian Medical Association describes leadership as a key enabler to transform health care (2019). The College of Family Physicians of Canada (CFPC) claims that the skills family physicians acquire during their training 'make them well suited to provide leadership within interprofessional teams' (2019, p. 22). In contrast, Kwon and Flood (2016) noted that although

physicians have many opportunities to take on leadership roles they receive little training in their medical education to prepare them for these roles. The national competencies for Canadian trained family physicians include that of leader and go on to indicate that the family physician must facilitate change within health care, engage others to impact the health system, and work with others to achieve practice transformation (CFPC, 2017). Contrary to this opinion, Olsen et al. (2021), in their Stanford-Intermountain Fellowship program, identified that only a small number of physicians have the skills set to lead health system change. This finding is in keeping with earlier work of Chreim et al. (2010) which found that the complex change, such as that required in the PMH context, requires multiple actors with complementary skills and resources as opposed to a hero-like leader.

As recently as 2019, in their revised PMH document, CFPC states the PMH team of health professionals must have continuous support and leadership from family physicians (2019). CFPC tempers this expectation by recognizing team composition will depend on professional competencies, skills, and experience tailored to the specific patient population needs. Further, CFPC recognizes that leadership roles may be assigned to different team members for clinical, governance, and administrative responsibilities. However, it remains unclear in many practices how, or if, this happens and who takes leadership of non-direct patient care aspects of the PMH, such as continuous quality improvement (CFPC, 2011). Berghout et al. (2020) reinforce this challenge in their work looking at professional un/doing in a medical leadership programme. Physicians were found to protect their professional identity as a heroic leader or a clinical leader (Berghout et al., 2020). The common heroic leader identity, positions the physician to interpret his/her self as individually responsible for shaping the new context required in the modern

healthcare environment (Berhout et al., 2020). The complexity of both patients, and the healthcare system, preclude heroic leadership as a mechanism for PMH transformation.

The WHO drives this home stating that health systems must avoid leadership models "that are dependent upon domineering individuals" (2016, p.12). Having said this, current practice change initiatives seem to continue to reinforce the dominant physician-centric, physician-reliant structures (Johansson & Lindhult, 2008). Alberta hosts a variety of opportunities for physicians, without any other PMH team members, to learn leadership skills and increase their knowledge of the PMH. A limited number of physicians attend these leadership programs. Further, there is limited evidence that the leadership training is clearly, or reliably, transferred back to the PMH following the learning opportunity. One of the challenges of this type of offsite classroom-based education is that even where a fixed curriculum, or doctrine, is taught the learning expresses itself in how it is practiced, received, and co-practiced in the home community (Lave & Wenger, 1991; Berghout et al., 2020). Unfortunately, these efforts have not demonstrated the transformational change the primary care system is searching for. The persistent leadership gap within the PMH requires further problematization, which I will now pursue through turning my attention to nurses working in primary care.

In parallel with physicians, it is expected that not all nurses will feel prepared, or interested, in enacting leadership. However, due to the limited number, and isolation, of nurses in primary care, even those with no leadership inclination will need to engage in leadership if we are to achieve the desired PMH outcomes (Embree et al., 2018). While medical bodies claim that leadership is an expectation of entry to practice for physicians, nursing bodies have been less

active on this item. At the time of writing my thesis, there were no provincial standards regarding the competencies of registered nurses (nurses) within primary care. National standards for primary care nursing were released in 2019 (Canadian Family Practice Nurses Association, 2019). These standards remain at a very high level and as of yet have not been broadly adopted. Although the provincial nursing college includes a leadership standard, it is unclear what specific leadership competencies are required and how they would be enacted within the PMH environment (College and Association of Registered Nurses of Alberta, 2019).

Compounding this issue, post-secondary nurse leadership training typically only occurs when the nurse moves away from clinical work and engages in formal management roles. Additionally, in contrast to physicians, there is limited accessible and affordable leadership training opportunities for nurses. What leadership training exists is impeded by the general lack of research regarding clinical leadership and PMH transformation (Nieuwboer et al., 2019). Consequently, even where nurse leadership training exists it fails to take into account the importance of the contextual relationships within the PMH (Crabtree et al., 2011). This research gap has left the current nursing workforce naïve to the competencies required to engage in interprofessional collaboration or leadership (Embree et al., 2018). Without a clear PMH leadership framework, or required competencies, nurses are left to engage in PMH leadership in an ignorant and unreflective manner, naïve to the complexities of leadership, which are magnified within the PMH.

One such complexity is that of role identity. Nurses, like other professionals, develop a professional role identity. Identity formation is complex and includes factors such as formal

education, professional group norms and public perception (van der Cingel & Brouwer, 2021). Professional role identity is further shaped by the individuals own experiences and/or perception of their experiences (van der Cingel & Brouwer, 2021; Joseph et al., 2021). Van der Cingel and Brouwer (2021) go on to reinforce that role identity perceptions are partially shaped by what the nurse believes to be of importance. Ogilvie, et al. (2012) considered the identity work involved when nurses move to a formal leadership position. Their work found that some nurses' perceptions of their nursing identity, and their leadership identity, were in conflict which resulted in psychological stress for the nurses engaging in leadership (Ogilvie, et al., 2012). Sorensen, et al. (2011), in their work considering nursing and leadership in hospital nurses, found that nurses fell into one of three groups: clinical leadership where the nurse leader was preoccupied with clinical work risking unstable and reactive management practices; managerial leadership where strong priority is given to management over daily operations risking professional isolation and harmful alliance formation; and finally hybrid-type leadership where nursing and leadership are variously accented allowing for the ability to assert a strong leadership role while developing mutual respect in the nurses professional community. The scarce research exploring nursing and leadership role identity is focused on nurses transitioning to formal leadership roles. The challenge of navigating nursing and non-positional leadership has not been meaningful explored in the literature.

An additional complexity of nursing leadership in the PMH is the potential of power differentials between physicians and nurses. Physician and nurse relationships have a long history of positioning the nurse as subservient to the physician (Sweet & Norman, 1995; Housden et al., 2017; Joseph et al., 2021). This relationship is reinforced in the PMH model where the physician

is identified as the leader of the multidisciplinary team (CFPC, 2019). Although there is substantial literature calling for physician-nurse relations to be more egalitarian, the literature tends to be prescriptive and based on anecdotes and opinions rather than empirical in nature (Sweet & Norman, 1995; Warelow, 1996). A recent example of this calls for nurse leaders to have "a strict zero-tolerance policy for incivility, bullying, micro-aggressions, and harassment" (Joseph et. al, 2021, p. 29). The worthiness of this call cannot be argued, however implementation of the call is far more complex. Nurse-physician power differentials remain an unsolved challenge due to several factors including the impact of organizational context on power differentials (D'Amour et al., 2005; Zelek & Phillips, 2003) and the ability of the individual to exercise power (Davis, 1991). Exploration of non-positional nursing leadership within the PMH would be incomplete without consideration of impact of physician – nurse power differentials on nursing leadership

Schruijer and Vansina (2002) argue that leadership is a complex problem of relating. Jones (2018) supports this argument, describing relating as occurring during person-to-person interactions, with a perpetual negotiation, taking into account the changing context of each actor (Jones, 2018). He goes on to identify leadership as residing with individual(s) who are able to constantly reconstruct and recreate the world (system) as the individual(s) in that world evolve (Jones, 2018). Raelin (2003) moves the concept of iterative leadership construction forward through his presentation of leaderful practice. Leaderful practice is juxtaposed to conventional leadership based on 4 continua where serial becomes concurrent, individual becomes collective, controlling becomes collaborative, and dispassionate becomes compassionate (Raelin, 2003).

Raelin (2010; 2012) further argues that development of leaderful practice requires both private and collective reflection as the practice emerges on an ongoing basis. He goes on to argue that the evolution of leaderful practice is founded in dialogue (Raelin, 2012). Unfortunately, although dialogue is recognized as a specific mechanism of leadership, and perhaps one of the most demanded competencies in today's workforce, this area is not well developed in the existing literature (Jian & Dalisay, 2018). I posit that a simple solution to PMH leadership has not been forthcoming because the complexity of leadership, and leadership enactment, within the PMH has not been given due consideration. Complex problems of this nature, sometimes called wicked problems, are recognized as being iterative, unique to context, and open to unknown solutions (Glourberman & Zimmerman, 2002). Wicked problems sometimes require unconventional answers and we therefore need to look outside of current popular leadership models to enact effective PMH leadership and bring the PMH model to fruition.

In summary, the PMH was implemented to deliver excellent healthcare that brings together primary care principles, patient centred care, information technology and the chronic care model in a sustainable manner. The PMH is currently not achieving its potential. Leadership is considered an essential criterion for supporting the PMH to fulfil its potential. However, the current leadership training model for physicians is failing to develop the scope of leadership needed for robust PMH transformation. One clear gap is that nurses have not been meaningfully considered in the PMH leadership discussion. Further, the limited primary care nursing leadership discussion, has not deliberated the impact of role identity on nursing leadership, the impact of physician – nurse power differentials on nursing leadership, nor the iterative nature of leadership and how it unfolds, and is influenced, within the context of primary care.

With this background in mind, the purpose of my thesis is to explore how non-positional nursing leadership is enacted by registered nurses within PMHs in Palliser PCN. The central question is, how do nurses perceive leadership and enact leadership in the PMH? The research aims to explore (a) the impact of role identity on nursing leadership in the PMH; (b) the impact of physician – nurse power differentials on nursing leadership in the PMH; (c) the impact of unrecognized leadership potential on nursing leadership in the PMH; and (d) the impact of lack of agreement, among nurses, about the nursing leadership role in the PMH.

STRUCTURE OF THE THESIS

Chapter 1 has described the background of the problem and importance, to me, of undertaking this inquiry to explore how to enact non-positional nursing leadership (NPNL) within the PMHs in Palliser PCN. My thesis proceeds to Chapter 2 which explores the literature relevant to understanding the research problem. I briefly review various leadership models, specifically looking at those that have been applied in the PMH. Further, I establish that the major leadership theories do not clearly address NPNL in the PMH. I outline leadership-as-practice as the appropriate lens through which to view leadership in the PMH. Further, I present NPNL as a process through which Raelin's Leaderful model may be implemented in in the PMH. I then explore the contextual issues impacting leadership in the PMH including nurse identity development within the PMH environment and physician – nurse power differential as it relates to nursing leadership in the PMH. Finally, I show how dialogue is an artefact of NPNL in the PMH, and at the same time, is a contextual influence towards NPNL in the PMH.

Chapter 3 outlines the philosophical perspectives underlying the methodological choices I have made to explore how NPNL is understood, and enacted, by registered nurses within PMHs in Palliser PCN. I explore philosophical concepts as they relate to the ontological and epistemological choices I have made in my thesis. I justify my choice of action research (AR) and most specifically a critical interpretivist mode of AR. I will conclude this chapter through addressing my data gathering methods and analysis choices.

Chapter 4 provides detail of the abductive approach I used for data analysis. This approach allowed me to move back and forth between my data and the literature to identify themes in the data. Through this approach I developed a visual metaphor which shows NPNL in the form of a flower whereby the centre (or pistal) of the flower is dialogue surrounded by petals denoting the themes I found in the data including identity, power, social influence, and competence. The flower head is supported on a stalk of reflection and reflexivity which is nourished through lifelong learning.

Chapter 5 details the workplace action I engaged in as I presented, and validated, the NPNL flower with the research participants in a focus group. Further, the participants used the flower to reflect on NPNL vignettes (Appendix 4) naturally occurring in their respective practice. The participants submitted these vignettes (Appendix 5) to me whereby I was able to create a master vignette (Appendix 6) to provide the foundation for my first NPNL workshop. This workshop used dialogue to accelerate NPNL enactment within the PMHs. Specifically, we used dialogue to critically reflect on the nurses' identity.

Chapter 6 is the concluding chapter of my thesis. I demonstrate that I have met my research aims of (a) exploring the impact of role identity on nursing leadership in the PMH; (b) the impact of physician – nurse power differentials on nursing leadership in the PMH; (c) the impact of unrecognized leadership potential on nursing leadership in the PMH, and (d) the impact of lack of agreement, among nurses, regarding roles and outcomes on nursing leadership in the PMH. I position my research in the field of action-based research. I reflect on my role as a researcher and a practitioner, and the implications for my practice. I describe the next steps in terms of practice-based implementation of my research within my workplace as well as the contributions my research makes to both theory and practice. Finally, I describe future areas for exploration and advancement of these concepts.

2 LITERATURE REVIEW

As established in Chapter 1, there is clearly a need for leadership to achieve the desired outcomes of Patient Medical Home (PMH) transformation. However, there is inadequate evidence on how to develop, and implement, this required leadership. Further, the paltry evidence available is focused on physicians. Both within the PMH literature, and my personal experience, this has had limited results. A gap in the literature, and a substantially untapped resource within primary care, is the enactment of non-positional nursing leadership (NPNL), by nurses, within the PMH. NPNL implies that a nurse may exercise leadership in efforts to transform the PMH without a formal position of responsibility or specified role in the PMH (Teleshaliyev et al., 2019). What meagre research exists around non-positional leadership is found in academia outside of North America.

My literature review considers literature relevant to the exploration of NPNL enactment in PMHs. My initial search terms included primary care leadership, nursing leadership, leadership, Patients' Medical Home transformation, health care change management, and Communities of Practice. I have completed my conceptual literature review utilizing a reference list backward snowball search strategy to allow for inclusion of the history of my research problem and to develop context around my research topic (Thomas & Hodges, 2010). Where an author had multiple publications related to my thesis topic these were explored. I endeavoured to consider research outside of the North American context where available. Further, I did not restrict myself to health, nor leadership, literature related to the paucity of research within nursing, combined with primary care, context. Literature from the discipline of education proved helpful

in understanding nursing leadership in the PMH. The range of my literature review helped me to establish that, although there is a large body of literature focused on leadership, there remains conflicting views regarding effectiveness of various models. Further, much of the empirical healthcare leadership research has been done outside the PMH and generalizability of existing leadership models to the PMH has not been clearly demonstrated. Finally, research on nursing leadership outside of formal leadership positions was scant. My literature review reflects my developing ideas regarding nursing leadership enactment in the Patient's Medical Home. My literature review includes both empirical and, to a lesser degree, theoretical evidence. Where I referred to theoretical evidence I endeavored to access source documents. The majority of my literature comes from journals. However, I did access some books, websites and government documents. Given the complexity of my research question, and the word limit of the DBA thesis, it was important that I continually challenged myself to narrow my search and limit the breadth of concepts I accessed, while still ensuring I explored the material with direct relevance to my research question. I used an abductive approach to my research which had me return to both my existing literature review, as well as exploring additional literature as I uncovered new information and questions throughout my research.

I begin my literature review with a brief overview of developing views regarding leadership theories and why the major leadership theories do not fit nursing leadership in the PMH. I present Raelin's leaderful model as a both a goal, and potential outcome, of nursing leadership in the PMH. I then explore the contextual issues impacting nursing leadership in the PMH including nurse identity development within the PMH environment, physician – nurse power differential as it relates to nursing leadership in the PMH, the impact of unrecognized leadership

potential on nursing leadership in the PMH, and the impact stemming from lack of agreement, among nurses, regarding leadership roles and outcomes within the PMH. Finally, I show how dialogue is an artefact of NPNL in the PMH, and at the same time, is a contextual influence towards NPNL in the PMH.

DEVELOPING VIEWS OF LEADERSHIP PARADIGMS

Traditional leadership models are based on the western cultural value of individual achievement against odds (Raelin, 2016b). The great man theory emerged in the early 1900's through the lectures and essays of Thomas Carlyle. The key argument of the great man theory is that key historical events can be attributed to a limited number of individuals who were born with natural traits and characteristics that enabled them to naturally lead others (Carlyle, 2013). These trait-based leadership theories, primarily focused on men and significant wartime events, grew in popularity in the early 1900s. Trait based leadership ties leadership success with the leaders' personality characteristics as well as demographic and physical traits and abilities (Walter & Scheibe, 2013). Trait based leadership is serial, individual, controlling or hierarchical, and dispassionate (Brewer et al., 2016; Raelin, 2005).

These traditional or heroic leadership models focus on the style and practices of the hero leader who holds vision and imparts the strategic pathway (Collinson, 2018; Raelin, 2016a). This one-dimensional construct of leadership limits leadership to a small number of individuals who must both be born with natural leadership traits and wish to exercise those traits in practice. An example of ongoing research interest in biologic leadership traits can be found in the leadership

research focused on extroverts versus introverts. Grant, et al. (2010) confirmed that the majority of high-level executives are extroverts. These leaders tend to be decisive, command attention, as well as possess strong social skills and a willingness to take risks (Farrell, 2017).

Trait leadership has continued to hold appeal in practice as evidenced in the 2006 Practice Nurse article on leadership skills in the primary care team by Howie and Hall. Howie and Hall (2006) made a call for nurses, within the National Health Service (the government funded health system in the United Kingdom), to move from clinical to strategic leadership. This article further identified that to be effective leaders, nurses must take risks, encourage, and lead by example, be flexible and creative in problem solving, as well as develop effective relationships with colleagues. This list of traits is not dissimilar to those identified above by Farrell. An ongoing albatross of trait-based leadership is the justification for not engaging in leadership. That is, if you were not born a leader, you have no responsibility or accountability in relation to leadership (i.e. you either are or are not a leader). This restricted focus on only those gifted with leadership traits significantly limits the pool of individuals with potential to lead and furthermore offers an easy out regarding responsibility to lead.

Trait theory morphed in the 1950s and 60s as researchers and educators made the case that leaders could be created, through learning behaviors, rather than just being biologically endowed (Germain, 2012). In 1961, Blake presented his managerial grid of behaviors demonstrated by leaders. This grid has undergone many revisions over the years demonstrating the ability of leaders to rely on certain behaviors, as well as hone their behavioral abilities. Even the beloved healthcare leadership model, LEADS, is renowned for not only providing a common leadership

language but also a set of leader expectations (Dickson & van Aerde, 2018). The popularity of LEADs is demonstrated through its use throughout the Australian and Canadian healthcare systems. Some large examples of use within Canada include the Canadian Health Leadership Network, the Canadian College of Health Leaders, Accreditation Canada, Canadian Foundation for Healthcare Improvement, and Alberta Health Services.

What is evident in the writings of leadership behaviorists, which have continued down the trait/behavior path, is the undercurrent that leadership is grounded in objective, positivist, and quantitative paradigms (Brewer et al., 2016). The conviction of trait and behavior-based theorists can be seen in their advancement of their particular list of traits. For example, Dickson and van Aerde (2018) promote the LEADS framework as a guide to select leaders. Further, although programs, such as LEADs, indicate that there may be multiple leaders in each organization, it is clear that leadership emanates from the individual. This focus on individual behaviors is in contrast to the World Health Organization (WHO) 2016 report on leadership in complex health systems. WHO (2016) was clear that models of leadership dependent on domineering individuals, or even accomplished leaders who make individual decisions, are elitist at best and poorly informed at worst.

This is demonstrated by the fact that, although there are multiple lists of leadership traits and behaviors, there remains a lack of congruence regarding the most appropriate list in general let alone in the PMH (Chandler & Chandler, 2013). Chambers (2002) states that nurse leaders need to have the personal attributes to articulate a vision and win over followers. However, she is unclear what these attributes are (Chambers, 2002). Additionally, the complexity, changing skill

mix, and blurring of professional boundaries (Nelson et al., 2018) within the PMH calls for leadership that capitalizes on the knowledge, skills and abilities of multiple people, moment to moment, as they engage in practice (Kempster & Gregory, 2017). In summary, neither trait-based leadership theories, nor behavioral leadership theories, sufficiently address the impact of situational elements on the leadership requirements in the PMH. An alternative PMH leadership solution may be found in post-heroic leadership theories.

An early post-heroic model is contingency theory whereby the leader employs a relations-oriented or task-oriented leadership style based on a prediction of how easily he/she will be able to influence the group being led (Hill, 1969). Some of the obvious challenges with this approach include the focus on the leader as the sole influencer as well as the assumption that others can be simply categorized and will follow. Alternatively, newer post-heroic leadership models recognize leadership as socially constructed and as a shared or distributed practice that can stretch across many actors, in many forms, which change over time and place (Collinson, 2018; Raelin, 2016a). Brewer et al. (2016) describe these models as being process centered, collective, non-hierarchical, and hosting a situated viewpoint. However, other scholars hint at a less egalitarian situation in which an autocratic and/or vertical leadership style can flourish if there are leaders and followers who share a like conceptualization of the leadership (Foldy, et al., 2008).

One such model that has been popularized in nursing is the leadership exchange theory (LMX). This theory focuses on the interaction between the leader and each subordinate. LMX shows increased engagement, privilege, and advancement for those individuals with high levels of

exchange with the leader (Barbara, 2018). Barbara (2018) recognizes that one of the weaknesses of LMX is found in the grouping of insiders and outsiders and the focus on the homogenized traits of these groups. The linkage back to traits reduces the opportunity for many to engage in leadership. Even where moved to a behavioral underpinning, LMX focuses on a leader and subordinate each with specific non-overlapping behaviors; once again this demonstrates an alignment with a positivist hero mentality. LMX is wholly inadequate in the PMH as there is often no formalized leader and, even where there is, the opportunities for privilege and advancement are limited related to the lack of a hierarchal structure.

A related theory, recognized for the opportunity provided to all subordinates, is that of transactional leadership. Transactional leadership positions the leader to influence his/her subordinates through determining a mechanism of reward and punishment (Bass, 1990). Exchanges within transactional leadership are primarily focused on economic, political, and psychological value (Boamah & Tremblay, 2019). The compliance rewards initiated in transactional leadership are focused on the leader maintaining the status quo through influencing the follower's compliance (Harris & Mayo, 2018). Further, transactional leadership recognizes that the leader and follower remain independent in their goals and interests (Tourish & Pinnington, 2002). Bass (1990) makes the case that transactional leadership is well suited for stable environments but where there is turbulence it is more appropriate to move to transformational leadership. As the essence of PMH is change (i.e., unstable), transactional leadership is minimally effective in this context.

Transformational leadership is an attractive post-heroic theory as it superficially aligns with the transformational change required in health care. Transformational leadership espouses leadership skills such as coaching and mentoring whereby the charismatic, socially distant leader challenges followers to engage in shared goals (Bass, 1990; Raelin, 2005; Harris & Mayo, 2018). Some researchers describe having an organizational leader with a clear vision as essential for PMH development (McNellis, et al., 2013). However, even by their own admission, the research designs make it difficult to draw conclusions around causal relationships (McNellis, et al., 2013). Additionally, transformational leadership is also based on individualistic, hierarchical view of leadership (Brewer et al., 2016), and thus suffers from similar problems as traditional models of leadership whereby there is not sufficient recognition of context including relations between individuals (Raelin, 2005). This is particularly important in the PMH where the environment is recognized as being dynamic and complex.

Further complicating leadership in healthcare is the implicit understanding that healthcare is supposed to be ethical and focused on the wellbeing of the patient. Hutchinson and Jackson (2013), in their critical assessment of transformational leadership in nursing, highlighted that early transformational leadership approaches have paid very little attention to ethics. Moreover, the focus on the transformational leader to set the corporate culture is antithetical to the benefits of team dissent often required for effective change and decision making (Toursih & Oinnington, 2002). Hutchinson and Jackson (2013) posit that the uncritical adoption of transformational leadership by nursing over the last decade has resulted in the limited, and perhaps weakened, perceptions of nursing leadership. This continued focus on heroic leader behavior is not in alignment with the PMH evidence showing improvement in patient care through team

collaboration and collective leadership (Dickinson, 2010; Cronholm et al., 2013). Where transformational leadership has shown success in the PMH it is based in practice (i.e., situated) and engenders a culture of self-examination (Chronholm et al., 2013). Effective transformational leadership imparts a shared vision to employees through communication (Jensen, et al., 2018). Jensen, et al. (2018) go on to state that transformational leadership is most likely to be successful where the leader engages in face-to-face dialogue with employees. This degree of reflective and reflexive PMH team communication is not readily evident in either the literature nor my practice based experience.

As we can see from the discussion of leadership theories, trait and behaviour theories perpetuate a focus on individual abilities and limit the scope of potential leaders. Even post-heroic leadership models remain focused on individuals, although they do pay more attention to environment and interactions. Of note is the association between transformational leadership and change management. However, as this is a top-down approach it still aligns with a hero mentality which is not likely to be successful in the dynamic PMH environment.

In summary, the complexity, within the PMH, calls for leadership that capitalizes on the knowledge, skills and abilities of multiple people as they take part in practice. I will now turn my attention to a leadership theory, leadership as practice, which recognizes the impact, value, and potential of context including the multiple actors within the environment.

SITUATIONAL LEADERSHIP: LEADERSHIP AS PRACTICE

Given the inadequacies of traditional and post-heroic models of leadership to address the needs of the PMH, it is worth considering more situational and context led models. One of these is leadership-as-practice (LAP). LAP offers a lens through which relationships, dialogue, and many other contextual issues, may be brought to the forefront of thought. This paradigm of leadership directly challenges post-heroic models with explicit recognition of the need to focus on situated understanding of what works, what does not work, and what might work (Raelin, 2016b). LAP provides a powerful leadership alternative as it moves leadership away from traits and behaviors of individuals to consideration of the intellectual resources that exist across a certain topic, in a particular setting and time (Raelin, 2012; Ringer, 2007). LAP recognizes that leadership is not abstract or solely cognitive as it occurs within the messy world of the workplace (Handley et al., 2006). The complicated problems faced in executing the PMH requires leadership that capitalizes on the talents of many people to bolster the effectiveness, efficiency and developing knowledge of this new era of primary care (Raelin, 2005).

A well-known 'as practice' model is distributed leadership, which takes into consideration the leader plus others who contribute to leadership outside of formal roles (Bolden, 2011). In his review of distributed leadership Bolden (2011) recognized similarities with shared leadership, collective leadership, collaborative leadership, and emergent leadership. Each of these theories has a nuanced perspective on how to distribute leadership, how to identify the goals of leadership, and how leadership emerges from a group of people (Bolden, 2011). Although this is a step in the right direction of capitalizing on the many instead of one person there is still a connotation of leadership occurring from discrete entities who are conscientious of the

environment but not necessarily shaped by the environment (Uhl-Bien, 2006). Bolden (2011) recognized this weakness in distributed leadership and challenges the scholarly acceptance of the existence of leadership as a concept for study.

Alternatively, leadership may be conceptualized as a collective social process which emerges, more or less, through interactions between multiple actors in many settings (Raelin, 2018a; Uhl-Bien, 2006). There is evidence that healthcare recognizes the value in collective leadership. For example, the popular leadership model LEADS has made efforts to understand leadership as being active within the environment (Chreim et al., 2010; Cleary et al., 2018). However, the move from a traditional hierarchical model in healthcare to a relational understanding of how to identify, improve, and change practice is proving elusive (Cleary et al., 2018). Relational leadership is a significant paradigm shift as it encompasses social influence process whereby social order and change emerge (Uhl-Bien, 2006). Consequently, relational leadership can, and does, occur among all actors throughout the organization and is both a product of and continually impacting the context (Uhl-Bien, 2006; Bradbury & Lichtenstein, 2000). This position is supported by West et al. (2015) who performed a meta-analysis of health care leadership research and found evidence to support collective leadership where the individual leading is dependent upon the situational context. Frost (2010, p. 209) brings further clarity to this concept defining leadership as a "human capacity that can be exercised by anyone". Although referring to the context of education, we can learn from Frost (2010) who went on to recognize that innovation and transformation will require leadership from the masses rather than a select few special people.

An emerging model bringing 'as practice' and relational leadership together is that of leaderful practice. Leaderful practice is based on 4 pillars: concurrent, collaborative, collective, and compassionate (Raelin, 2003). This model has similarities to distributive, collective, and shared leadership; however, it is more clearly focused on social processes. Raelin (2012) describes leaderful practice as occurring where an underlying sense of civility and commitment to the common good trumps self-interest. He goes on to state a shared sense of caring, mutual responsibility, and psychological safety, including openness and mutuality of presence, are evident in leaderful practice (2018b). Further, Raelin (2016) claims that within leaderful practice the communities of practice are inclusive and devoid of inauthentic behavior or intentions.

It is evident that Raelin has a rather optimistic outlook on these social processes and, consequently, he has been criticized for his lack of critical engagement, specifically around power relations, control practices, and identity construction (Collinson, 2018). This weakness in the leaderful model must be addressed when considering non-positional nursing leadership in the PMH where the ongoing power differentials between physicians and nurses are magnified as the physician is typically the owner of the PMH. Although Frost (2010) does not address these weaknesses he provides a self-focused lens through which he considers non-positional leadership. Frost (2010), in his empirical research with teachers, states that individuals demonstrating leadership, irrespective of being in positions of responsibility, demonstrate the below actions. I have mapped Frosts leadership actions with Raelin's 4Cs of leaderful practice (in brackets).

- Take the initiative to improve practice (compassionate)
- Act strategically with colleagues to embed change (concurrent)

- Gather and use evidence in collaborative processes (collaborative)
- Contribute to the creation and dissemination of professional knowledge (collective).

Cunliffe (2009) agrees with Raelin that leadership is relational, reflexive, and situated. However, she also recognizes the messy side of leadership as it emerges from exploration of our actions, dialogue, and ways of making sense; including consideration of power (Cunliffe, 2004; Cunliffe, 2009). Despite the above stated criticisms, leaderful practice, through its focus on dialogue, collectively and 'leadership as it happens' remains well positioned to empower nurses to embrace and effectively work within their current circumstance rather than lament for the physician 'great man' leader to emerge and activate change within the PMH (Raelin, 2018b).

Finally, leadership-as-practice models of leadership open up both the scope of potential leaders, as well as offer the opportunity to pay attention to the relationships, and context, in which leadership occurs, as an ongoing experience. As I will show in my thesis, the experiences of leadership are readily described by those outside of formal leadership roles. However, these experiences are often not identified under the label "leadership". This phenomenon is supported by Juntrsook et al. (2013) who found their interview participants, at a New Zealand university, were able to articulate stories about their leadership despite no formal recognition as leaders.

This section of my literature review highlights the differing understandings of leadership and who is eligible to lead. Therefore, it will be important to explore the nurses' views on the nature of leadership, the role of leaders, and how these concepts relate to the nurse in the context of the PMH.

NEGOTIATING MULTIPLE COMMUNITIES OF PRACTICE IN THE LANDSCAPE OF THE PATIENT'S MEDICAL HOME

The iterative emergence of leadership, through contextual relationships, is dependent on the interactions of identity, power, and dialogue as leadership is practiced. In this regard, the theories of Communities of Practice and Landscapes of Practice address the issues of identity development, power, and dialogue. Subsequently these theories will be applied to further explore the nuances of emergence of non-positional nursing leadership in the PMH.
Thus, to further the conceptual foundations of my thesis I will first discuss Communities of Practice (CoP) as it relates to the nurses' understanding of his or her self as an actor within the PMH.

The concept of CoP originated in work by Lave and Wenger (1991) in which they argued that learning does not reside with an individual but rather is a social or shared process that is situated in both cultural and historical context. The entirety of that which contextually impacts a practice may be described as the community. Practice refers to engaging fully in a task, job or profession (Brown & Duguid, 2001). Further, practice is informed by knowing and knowing is informed by practice such that one cannot be fully discussed or understood without the other (Lave & Wenger, 1991; Brown & Duguid, 2001). It is important to distinguish knowing from knowledge. Knowing aligns with the concept of learning which in turn is considered a process of identity construction or becoming a different person (Murillo, 2011). Knowledge may be considered an artefact or product of knowing (Omidvar & Kislov, 2014). Knowledge, foundationally, exists at the level of the individual, encompassing the unique practice of the individual, and thus incorporating the tacit dimension that people cannot easily say (Polanyi, 1962). Pyrko, et al. (2017) describe this concept as "indwelling" whereby the individual spends time within an area

of knowledge such that one's self-knowledge becomes an extension of self. Individual practice or knowing develops as the newcomer engages with the language, implicit relations, tacit conventions and underlying assumptions and values of the old-timers (Handley et al., 2006). Further, the CoP helps us to consider how newcomers are socialized and learn "to be" within an organization (Macpherson & Antonacopoulou, 2013, p. 268).

Core membership in a CoP requires transactional knowledge on how to get the job done, as well as socio-cultural competence, including embracing the values, attitudes and professional norms that characterize the core members, (Dunn, 1999; Holmes & Woodhams, 2013). The newcomer develops his/her practice as they determine how they will match the community norms, or perhaps adapt, transform, or even reject them in efforts to stay true to their own sense of self (Handley et al., 2007; Ibarra, 1999). Thus, practice evolves at both the individual level and at the community level (Mork et al., 2010). This practice evolution is not something that can be predicted or taught as it is uniquely produced by the community that engages in it and the community in which it occurs (Wenger & Snyder, 2000; Farnsworth, et al., 2016). That said, as practice develops, through a sustained history of social learning, it will, by definition, develop a boundary around itself for those who have not engaged in the same history (Farnsworth, et al., 2016). This boundary is evident in the defining of competence by a professional group (Wenger, 2000). A practical example of this boundary is found in the creation of terminology around liability that physicians use. Physicians use the term 'medicolegal liability' whereas all other health care professionals simply use the term liability. It is clear that physicians have a well-developed CoP and further that physicians specializing in family medicine have an additional

CoP. I will now consider the entry of nurses into these CoP and, further, the risks nurses face as they try to become community members.

Given the relatively brief history of nurses working within the PMH, the almost non-existent nursing academic consideration of the PMH, and minimal professional nursing attention given to the PMH, nurses begin their PMH journey on the periphery. In colloquial terms, one of my colleagues describes this as being on the outside of the candy store scratching to get in. However, time spent at the periphery is not only necessary but invaluable from a newcomer learning perspective. Lave and Wenger (1991) describe this time when the newcomer, the situation, the social interaction, and learning are occurring as legitimate-peripheral-participation (LPP). Lave and Wenger (1991) go on to claim that, even without intention, a newcomer to a group will learn ways of speaking and acting to attempt to become more like the insiders at the centre of the group. These shared narratives are developed within the dynamic of the CoP to demonstrate the communal, and thereby collaborative, nature of work. These narratives are created through situated language with a distinct body of grammar and vocabulary as well as appropriate relational or interpersonal skills and social interaction practices (Dunn, 1999; Holmes & Woodhams, 2013).

This concept is reinforced by Garrett and Baquedano-Lopez (2002) who found that the nurse, as a novice in the practice, learns and adopts the language of the expert, normally the physician. Likewise, Dunn (1999) found that it is not unusual for a nurse, who is beginning to work in a PMH clinic, to acquire the discourse patterns/style of the physician(s) they work with in efforts to move towards an integrated role in the clinic. This is evident in the language choices nurses

entering the PMH make such as moving from use of the word client to the physician centric term patient. It is clear that the nurse strives to move from the outer boundaries of the PMH towards being a full member with his or her physician(s) colleagues. However, this focus on becoming an insider has some associated challenges I will now consider.

One of the risks associated with shared narratives is the perception that dissent should not occur particularly where a member has been accepted into the core of the CoP (Tourish & Pinnington, 2002). In alignment with CoP research (Lave & Wenger, 1991), my experience is that socialization of the novice nurse into the PMH is typically facilitated by the experienced physician. Unfortunately, in most circumstances, the physician facilitates the nurses' learning based on his or her knowledge of the traditional medical clinic, not the relatively new PMH. Where this transition from the periphery to the core of the PMH goes unchallenged, there is risk that the nurse may lose his or her identity and sense of self, as well as develop an identity more in alignment with older models of primary care (Handley et al., 2006). However, Fuller and Unwin (2004), through their research with apprenticeship, found the apprentices reported spontaneous teaching sessions in which they were helping more experienced older workers learn. Unfortunately, the newcomer influence in the CoP may result in variation and possibly conflict (Handley et al., 2006). Carlile (2004) states this conflict may be the highest, and newcomers may be the most constrained, where the newcomer threatens to alter the knowledge and practices of the community. This concept is meaningful in the PMH as the PMH moves the traditional family physician clinic towards a more patient-centred chronic care approach. This new approach is more familiar, and in alignment, with current nursing models rather than physician disease focused models.

It is clear that physicians and nurses each come to the PMH from a profession specific CoP. These profession specific CoP mean the nurse is unable to separate his or herself from the personal knowledge he or she brings into the PMH (Pyrko, et al., 2019). The CoP research supports this legitimate peripheral participation role for nurses. Further, the CoP research, indicates that from this position nurses can lead learning, and change, within the PMH. This perspective is supported by Harris and Mayo (2018) who argue that leadership can be practiced by individuals who do not hold official positions. Although Lave and Wenger (1991) acknowledge that newcomers do not passively sit on the periphery of the constantly changing and iterative CoP, it is unclear what form active newcomer participation takes.

In her 2003 study of different CoP in a manufacturing company Bechy (2003) described the misunderstandings and communication difficulties which arose as different CoP met to discuss a problem. She described how each CoP brought their unique understandings of the problem at hand. Transformation occurred as each CoP came to understand, and fit, the knowledge of the other CoP within the context of their own work (Bechy, 2003). Mork et al. (2008) found this same phenomenon in their study of health care professionals at an R&D company. The collaboration among the professionals was defined by tension as new knowledge was built upon the knowledge of existing CoP each with its own epistemological foundation (Mork et al., 2008).

A line of exploration could be on how to foster a new PMH CoP. However, given the professionally ingrained CoP physicians and nurses independently belong to I am more interested in the processes that occur between the spaces of the CoPs (Mork et al., 2008). Pyrko,

et al. (2019, p. 483) use the concept of Landscapes of Practice (LoP) to explain how different CoP interact, depend on, and are accountable to one another's practice based knowing. CoP competence is dynamically shaped by an individuals' experience and the communities' iterative definition of competence (Farnsworth, et al., 2016). The expected competence of a nurse in the 1800s is quite different than that in 2021. As new knowledge and experiences becomes available the CoP may change its definition of competence and / or marginalize the new information or newcomer (Farnsworth, et al., 2016).

Competence within the PMH cannot clearly be defined related to the complex bringing together of multiple CoP within the landscape of the PMH. As a brief example, consider the unique CoP of physicians, family practice physicians, nurses, family practice nurses, practice improvement facilitators, office managers, researchers, regulators and associations, each with their own histories, domains and definitions of competence (Farnsworth, et al., 2016). Pyrko, et al. (2019) identify the concept of knowledgeability to describe a person's relations to multiple situated practices as they interact across a landscape. The metaphor of landscape expands the communities' concept towards a more robust consideration of boundaries, multi-membership in communities and personal trajectory (Farnsworth, et al., 2016). The landscape metaphor is in alignment with Fuller et al. (2005) who claim that newcomers, with their unique education, skills and experiences, may change the CoP as they have multiple interactions with individuals, the community and the wider context. Brown and Duguid (1991) also support this perspective noting that bi-directional influence may hold the potential to change the community's viewpoint and in turn lead to innovation in the communities of practice. Subsequent to these efforts, the newcomer may develop a new identity with new practices (Handley et al., 2007).

This section of my literature review provides an overview of CoP and how this helps individuals develop meaning, or a way of talking about experiences, history and competence (Murillo, 2011). Further, this concept outlines the social aspect of learning and identity development within a CoP (Wenger, 2000). The nurse entering the PMH brings, at minimum, the knowledge and competency associated with the professional CoP of which he or she is already a member. Much of this pre-existing knowledge only exists within the realm of tacit knowledge and as such is only available as it is redeveloped among the interacting CoP (Pyrko, et al., 2017). Additionally, the nurse might also belong to a specialty (e.g. emergency nursing), or may have only worked in one physical area of practice such as an acute care facility. Each of these aforementioned situations results in a CoP with an identity of its own.

This same structure of multiple CoP can be developed for physicians within the PMH. I established that these various CoP are not self-sufficient and isolated but rather co-exist across the LoP of the PMH (Brown & Duguid, 1998). The members of a LoP negotiate identity through the activity of participating, or non-participating, and in turn learning or social becoming (Wenger, 2004). Wenger-Trayner, in his 2014 interview with Omidvar and Kislov, identified that the knowledgeability required to support role identity is to be found through the complex relationships people establish across the LoP. Knowledgeability, within a complex LoP, is further developed through a constant renegotiation and reconfiguration of boundaries, identity and meaning (Omidvar & Kislov, 2014). Therefore, it is important to explore the nurses' views on which CoP they belong to and how this has shaped their identity. Additionally, it is important to explore the nurses' views on the permeability of the various CoP across the LoP of the PMH.

Identity Construction in Communities of Practice

An important outcome, noted above, of participating in a CoP is the emergence and construction of identity. Lave and Wenger (1991) describe CoP as consisting of a practice whereby there is legitimate peripheral participation and learning (as equated to the construction of practitioner identity). Efforts to capitalize on the potential of NPNL will require that nurses working in the PMH develop leadership role identity (Carroll & Levy, 2010).

Further to this, leadership is an iterative, relational, complex and constructive process (Carroll & Levy, 2010; Ford & Harding, 2007; Hersted & Frimann, 2016). The ongoing emergence of leadership both provides opportunities for, and relies on, participation in a CoP along with development of identity (Handley et al., 2006). Leadership identity construction is important for many reasons not the least of which is as a driver of leadership behaviour (DeRue & Ashford, 2010). Early shaping of self happens through the education process as professionals begin to recognize themselves as a member of a professional group. Some researchers make the case that, in order to engage in interdisciplinary work, a professional must be secure in his/her own professional discipline, while other researchers make the argument for integrated multi-professional education programs (Hall & Weaver, 2001). Tang, et al. explored this subject using an integrated literature review approach (2013). Their findings noted physician-nurse collaboration literature is primary addressed in the Western hospital environment. Further, given the complexity of physician-nurse collaboration improvement would likely require changes in policy and practice coupled with integrated post-graduate education (Tang et al., 2013). Matthys, et al. reveal systemic issues regarding physician-nurse collaboration in their 2017

overview of systemic reviews regarding collaboration between physicians and nurses and the impact on patient outcomes in primary care. In their conclusion, Matthys et al. (2017) note that physician-nurse collaboration may have a positive impact on patients and that along with more collaboration there needs to be sufficiently educated nurses. Clearly, this issue has yet to be resolved, and to date there are limited opportunities for integrated leadership education programs for physicians and nurses in primary care (Power et al., 2016).

Professional socialization research remains relatively meagre with the work primarily focused on how the peripheral participants become fully integrated participants (Roberts, 2010). Roberts (2010) sees this process as not having room for reciprocity with the outsider moving in a stepwise fashion towards becoming an insider. This line of argument is in keeping with Lave and Wenger who identified substantial status differentiations among masters and apprentices (1991). DeRue and Ashford (2010) challenge this perception claiming that identity and role evolve interactively such that new role synthesis occurs. Piaget (c. 1951) saw the individual as aligning with a new experience either through assimilation (perception of new experiences in terms of existing mental structures) or accommodation (the changing of internal mental structures to be consistent with perceived external reality) (Yip & Raelin, 2012). In other words, the individual will not resist the new role but will change his/her mental model (identity) to align with the new role. In contrast Handley et al. (2006) state that identity regulation encompasses the individual's response to the community namely in the form of resistance or enactment of the role. As individuals are exposed to a community, they determine how fully they will reject or embrace participation opportunities.

Ibarra (1999) identified an alternative to the binary choice of role acceptance or rejection suggesting that individuals will try out provisional roles while they engage in practice and eventually refine their new role. This perspective is inherently flawed when applied to the PMH where there currently are no in-practice nor empirical descriptors of what the new role can or should encompass. Further complicating this situation, registered nursing education remains relatively silent on the context of primary care and rarely offers clinical placements in this area. Subsequent to this, when nurses are hired into a primary care role their frame of reference is typically acute care. Acute care remains highly institutionalized with strict hierarchy, policy, and protocol and very little room for leaderful practice (Realin, 2003). Reinforcing these leadership challenges much of the PMH team research places the physician at the helm of the PMH with other health care providers in a supporting role (Giannitrapani et al., 2016). This notion of other health providers supporting the physician has the physician redistributing tasks that he or she had previously done.

This foundation is flawed as we look at transformation of clinics to the PMH (which typically no provider, including physicians, has done). There is substantial discussion in PMH research regarding each profession knowing the scope of practice (role) of other professions and further, that each profession should be working to the top of their specific scope of practice. However, if we are to successfully develop the PMH we must be prepared to have fuzzy role boundaries allowing us to do work previously done by others, as well as new work, and yet to be known work, while still maintaining a clear sense of self (Giannitrapani et al., 2016). For example, in their work around change agency in primary health care Chreim et al. (2010) found that PMH teams need to have collaborative skills and mindsets which move beyond professional

boundaries such that change leadership is dynamically enacted by different team members. Supporting this finding, empirical evidence is showing that where PMH teams are having success they are engaging in distributed knowledge, work activities, and shared mental models (Enact Alberta, 2018). However, Currie and Lockett (2011) caution that there is not a clear definition of distributed leadership and to date the issues impacting enactment of distributed leadership such as power, relationships and context, has been largely ignored.

It is clear that as identities are being constructed tensions are exposed and individual participation reflects both ability, and willingness, to engage in conflict (Macpherson & Clark, 2009). Mork et al. (2010) argue that dissonance and negotiations should be expected as individual actors, within a CoP, argue for those items that align with their interests and professional standards. Morrison (1993), and Pare and Le Maistre (2006), offer a more optimistic appraisal of newcomer participation with their findings that newcomers, who proactively seek information, tend to have easier access to the community as well as greater potential to change the habitual practice of the community. These findings are in aligning with Murillo (2011) who identified learning within a CoP as a process of identity formation rather than procurement of knowledge artefacts. Brown and Duguid (1991) argue that social construction of both identity and collective knowledge occurs through developing shared meaning and becoming proficient in the telling of stories about the practice. Empirical research by Brue and Brue (2018) has shown that where an individual accepts a new narrative of their leadership identity, they feel a sense of belonging in the new role.

This section of my literature review highlights the importance of identity construction in each of the roles the nurse occupies. As Wenger (2000) developed his CoP concept, he came to recognize that individuals participate in several CoP and that these CoP may overlap and have interaction not just within a CoP, but between CoP. Handley et al. (2006) support this concept identifying the space between multiple CoP as the site for identity development. Murillo (2011) reinforces the importance of CoP boundaries as a mechanism by which practitioners gain a sense of identity, practice and meaning. Subsequently identity is an artifact of the various CoP that nurses and physicians bring with them to the PMH. As the nurse tries to join a primarily physician CoP the boundaries may be more or less permeable making entry more or less difficult. Further, as the nurse journeys across the PMH landscape, new PMH identities are constructed. As the new identity develops it will be impacted by factors such as security in professional CoP, knowledgeability in the PMH LoP, ability to articulate habituated practice, and ability to seek information from other LoP travellers (i.e., family practice physicians) to develop new PMH mental models. Thus, understanding and incorporating the nurses' views on identity development as a nurse working in a PMH, as a transformative member of the PMH, and as a nursing leader within the PMH, will be essential for understanding nursing leadership emergence within the PMH.

Power in Communities of Practice

Contu (2014) found that there is a reciprocal influence of power on identity construction and identity construction on power. PMH transformation literature is replete with support for egalitarian teams within the PMH. However, the relatively new PMH model is fighting years of healthcare experience utilizing a hierarchal team model. As indicated earlier, the frame of

reference for most physicians and nurses in the PMH is the hospital environment. Here there remains an institutionally sanctioned hierarchy of occupations which calls for deference to physicians in health matters (Chreim et al., 2010, p. 195). Andresen and Potter (2017) note that despite the significant evidence supporting the value of empowering leadership to enable engagement and communication, which in turn fosters interdisciplinary teamwork, healthcare remains hierarchical with a continuing prevalence of domination relationships. Although great strides have been made to impact this power imbalance, it remains today, and perhaps is even more pronounced where the nurse works in a physician owned and operated clinic.

This issue must be addressed as successful innovation and adaptation to the complex and dynamic environment of the PMH requires a large repertoire of knowledge and leadership that cannot be found in the heroic-hierarchical model of leadership (Stacey, 2011). Dickinson (2010) sees the hierarchy in the PMH as inevitable related to the hierarchical and bureaucratic environments family physicians are trained in, and professionally socialized in, as they enter practice. Further, many physicians believe they must be at the centre of all decisions in the PMH due to legal concerns (Dickinson, 2010). The impact of professional socialization has been shown to impair the professionals' ability to take on roles outside of their core professional values (Edwards et al., 2017). This may play out in how PMH nurses value both their own, and the physicians, professional leadership roles. Adequate investigation of NPNL in the PMH will require us to move beyond describing the quality and type of relationship (traits) to an understanding of the social dynamics, including power, by which the leadership relationships form and evolve (Uhl-Bien, 2006).

One such dynamic is the understanding that these power imbalances may lead to low-intensity conflicts within the clinics as the nurse struggles with persistent occupational identity boundaries (Aperosa-Varano, 2013). This finding is not unexpected in a CoP where periphery relationships may be defined by inequality, lack of respect, and a lack of collaborative dialogue (Handley et al., 2006). Further, professionals tend to associate power with expertise and experience (Levina & Orlikowski, 2009) and as such perceptions of expertise and experience may cloud attributions of power dynamics within the PMH. In other words, assumptions and misunderstandings may lead PMH team members to assume PMH expertise and experience exists, where in practice it does not.

These false assumptions may subsequently lead PMH team members to perceive and/or assign power inappropriately. Through their study of medical innovation projects, Mork et al. (2010) are so bold as to suggest that contestation of expertise within a CoP is part of the journey towards innovation and change. In other words, in a transformational environment, such as that desired in the PMH, it would not be unusual for expertise to be incorrectly attributed to one agent or another. Although this boundary work is concerning at first glance, it is here at the boundaries of CoP (such as the physician CoP and the nurse CoP) that the division of work is destabilized and thus more amiable to renegotiation, reconfiguration and change (Mork et al., 2010). This negotiation eventually leads to a new definition of competence that includes knowledgeability of other practices across the PMH LoP (Gherardi et al., 1998).

Power relations must be accepted, and even embraced, as they are recognized to be pervasive where we are learning in practice (Vince, 2006). I suggest a reframing of power, from a negative

hierarchal structural consequence, to the ability to take action and initiate interactions towards achieving desired outcomes or effects (Contu, 2014; Downey, Parslow, & Smart, 2011; Urmston, 2000). This reframing is in alignment with the concept of mindset, one's way of thinking and opinions, which is developed through an ongoing cognitive process impacted by others and self (Cambridge Dictionary, Accessed September 28, 2019). Pyrko et al. (2019) extend this thinking beyond cognition to the social processes, and relationship development, that individuals create to navigate their way through a LoP.

This view of leadership as a socially and relationally constructed mindset may be different for women, rather than men, due to women being considered more interactive and relationally connected than men (Brue & Brue, 2018). These gender related power issues may be important as we look at NPNL in the Palliser PCN PMHs where the vast majority of primary care nurses are women (at the time of writing my thesis 100%) and the vast majority of physicians are men (at the time of writing my thesis 76%). However, Pyrko et al. (2019) point out that the practices across a LoP are new and as such will demonstrate ontologically different characteristics than the social groups, or practices, from which they originated. Further, the local practice will be an amalgam of tools, frameworks, and activities, which the LoP members adopt to carry out their unique day-to-day practice (Gherardi et al., 1998). The development of a completely new practice may dampen the potential gender impact on power issues within the PMH.

This section of my literature review has demonstrated that identity is revised when moving through the PMH LoP and it will inevitably create tensions and power issues both within individuals and in the space between them and the CoP they occupy (Farnsworth, et al., 2016).

These power issues are even more pronounced when we considered historical power imbalances between physicians and nurses, as well as men and women. Therefore, understanding the nurses' views regarding power as it relates to identity development, must be considered in understanding nursing leadership emergence within the PMH.

Dialogue in Communities of Practice

I have considered how identity construction and power manifest among the CoP in the PMH LoP. I will now turn my attention to the impact of the PMH on dialogue (an artifact) as well as the impact of dialogue within the PMH (a tool).

Raelin (2012) argues that dialogue helps us to articulate the mental models that guide our action and further allow us to examine if our models are leading us towards constructive involvement in collective action. This concept is empirically demonstrated by Summers and Nowicki (2005) who confirmed the ongoing power imbalance between physicians and nurses through their research considering nuances in language. Additionally, Levina and Orlikowski (2009) argued that power and discourse are linked in such a manner that power can be explored through discourse reflection and reflexivity. Alvesson and Karreman (2000) expand this concept arguing that we must move beyond the representational capacity of dialogue to the functional purpose of dialogue recognizing the outcomes created through dialogue choices. That is, dialogue must be positioned as a primary social and cultural action, rather than a secondary outcome of action (Lave & Wenger, 1991).

Shotter (1997) supports this argument reminding us that dialogue is important as it is the outward manifestation of our conscious and unconscious sensemaking that is shaped by our continuous interaction and reaction with the situations we are experiencing. Levina and Orlikowski (2009), through their empirical study of interorganizational projects, support the concept of drawing upon pre-existing knowledge and experience such that an agent can purposefully impact the discursive practices shaping power relations and potential transformational change. This argument is further supported by Cunliffe (2016) who describes language as being both shaped by, and having a role in shaping, our understanding, perspective, assumptions, and paradigms. Shotter (1996; 2006), in his endorsement of Wittgensteinian investigations, supports the exploration of dialogue, and thus what is currently known and understood, as a journey to solve problems rather than an assumption that we need to learn something simply unknown to us. Awareness of dialogue as both a manifestation, and tool, of leadership will enable the nurse to focus on what is possible within his or her unique PMH context.

Dialogue, within traditional leadership models, is based on transaction: I do something for you, and you do something for me (Raelin, 2016b). Newer leadership models soften the notion of transaction while recognizing that reciprocity allows for both the transmission, and ongoing development, of culture using communication (Somacescu, et al., 2016). Lonsmann (2017) supports this stance claiming that newcomers are socialized into existing linguistic norms and at the same time their dialogue choices may change the language norms. Language has the potential to be transformative (Roberts, 2010) as the landscape of the PMH develops. This perspective is supported by Garrett and Baquedano-Lopez (2002) who argue that the creation of new linguistic norms offers the opportunity for innovation and change. They further argue that bi-directionality

in language socialization shows that the novice brings pre-existing knowledge or expertise to the workplace dialogue (Garrett & Baquedano-Lopez, 2002).

As such dialogue is amiable as a PMH change tool where it is purposefully chosen, and enacted, to further a leaderful practice environment specifically striving to achieve the four C's of leadership (concurrent, collective, collaborative and compassionate) (Raelin, 2003). Subsequent to this, leadership is positioned not as set of known skills or desired outcomes, but rather as an iterative CoP learning mechanism that accounts for past and present power and identity, as expressed through, and shaped by, dialogue (Contu & Willmott, 2003). This is an exciting turn of thought as it opens the opportunity for small iterative change to make a substantive difference within the PMH. However, it is imperative to remember that changing the language in the PMH is not an end goal in and of itself, but rather a means to engage in leadership that supports PMH transformation (Lonsmann, 2017). Through purposeful dialogue the leadership discourse manifest in physician-nurse relationship within the PMH LoP may be impacted in a manner which brings the promise of the PMH to fruition.

This section of my literature review has demonstrated that dialogue is (a) an artefact of an existing CoP, (b) a product of interacting CoP within a LoP and (c) is the mechanism through which CoP actors may purposefully enact leadership in an iterative manner. Therefore, it is important that my research explores how nurses use dialogue when speaking about their leadership role in the PMH, how they perceive their dialogue to be changing as a result of working in the PMH, and finally how they might use dialogue to influence a leaderful practice environment striving towards achievement of the four C's of leadership (Raelin, 2003).

In summary, I provided an overview of CoP and how this helps individuals develop meaning, or a way of talking about experiences, history and competence (Murillo, 2011). I highlighted the social aspect of learning and identity development within a CoP (Wenger, 2000). Further, I established that these various CoP are not self-sufficient and isolated but rather co-exist across the LoP of the PMH (Brown & Duguid, 1998). The members of a LoP negotiate identity through social becoming (Wenger, 2004). These social relationships manifest through overlapping and bi-directional influencing concepts of identity development, power, and dialogue. It is out of this social phenomenon that leadership emerges. In the final section of this chapter, I will consider where and how non positional nursing leadership emerges within the PMH.

EMERGENCE OF LEADERSHIP

As developed above, nurses and physicians come to the PMH environment with entrenched professional CoP. Ferlie et al. (2005) argue that strong professional affiliation results in less permeable social and cognitive boundaries between the groups. Related to being profession specific, defensive of jurisdiction and group identity, and being highly institutionalized, the boundaries between professional groups are much stronger than the non-professional boundaries previously identified by Wenger (Ferlie et al., 2005). However, I contend that NPNL may emerge in the space between multiple CoP such that boundaries are blurred, and action is yet to be determined. Giddens, a structurationist, promotes this space of conflict and tension as the area where uniqueness may be leveraged, and change can occur (Whittington, 1992). Whittington (1992) indicates that in this space of emerging leadership the individual agent(s)

choses to accept or reject social approval and legitimacy of various CoP of which they are a member. Leadership emerges from, and impacts, practice situated action, and dialogue between a network of people (Downey, et al., 2011). Shotter (2003) makes this argument even more explicit stating that it is not until an object or event is talked about that it becomes a social reality and, as such, we are enabled to take action. The social reality that exists in the 'space between' has two significant impacts on NPNL in the PMH. First, each actor is impacting leadership and change whether intentional and preferential or not. Second, leadership is in a constant state of contextual emergence. Therefore, rules and principles of leadership will never be wholly effective as they miss the moment-by-moment links and relations (Shotter, 1997; 2005).

There are two techniques we can use to make sense of situated leadership emergence: reflection and reflexivity. Reflection is a simplifying process through which we look for patterns and logic (Cunliffe, 2002a). Reflexivity is a complexifying process through which we look for contradictions, doubts, and possibilities (Cunliffe, 2002a). Reflexive dialogue is the action through which we question our fundamental assumptions, our values, and our ways of interacting with others (Cunliffe, 2009). Explicit recognition that our communication recursively assimilates the narrative (what was) of others may enable more fulsome and purposeful dialogue choices (what could be) (Cunliffe, 2002b; Raelin, 2012).

Druskat and Pescosolido (2002) provide an empowering approach through which to consider team leadership by focusing on the ability to manage one's own behaviors through psychological ownership of self. Cunliffe (2009) supports this concept in her work around the philosopher leader whereby she describes leadership as a process through which we think more critically and

reflexively about ourselves, our actions, and the situations we find ourselves in. Cunliffe (2009), like Raelin (2003), recognizes the intersubjectivity of leadership; however, she gives acknowledgment to the power, perhaps responsibility, of the individual to interpret, judge and act upon the emergent self.

Uhl-Bien (2006) supports this view stating that any formulations of thoughts and assumptions must be understood through conversations and iterative relations. Contextually sensitive leadership requires engagement in self-reflection and critical reflexivity (Hibbert & Cunliffe, 2015). In turn, reflection and reflexivity, as co-constructed actions, impact the emergence and enactment of relational leadership (Cleary et al., 2018). Using reflection, the leader is able to move away from a place of blame and victimization to a place of control and acknowledgement of a collective identity (Cleary et al., 2018). Raelin (2016a) states that choice is so powerful that it may have transformative impact on a given system. Cunliffe (2009), further supports the power of the individual through her description of reflexivity as a process to give rise to our personal accountability for our self, our actions, and our relationships with others. Cunliffe's (2004) thoughts around critical reflexivity and social constructionism align with my focus on dialogue as a mechanism to both expose and impact non-positional nursing leadership in the PMH. Raelin (2012) also recognizes the power of the individual in his description of dialogue and democratic leadership. Through his description of democratic leadership Raelin (2012) moves away from the requirement of egalitarian dialogue when he confesses that who socializes who, within an organization, may exclusively depend on who possess superior dialogue skills. As we engage in critical reflection with others, considering how we see our self, how others see us, and how we understand how others see us, we will come to know and be able to influence,

the world of which we are an active part (Raelin, 2016a). These dialogue skills enable us to engage in collaborative practice (Embree et al., 2018). Further, these reflective and reflexive conversations are required to enable the questioning of our being and acting such that we are able to develop new ways of talking and acting (Cunliffe, 2002a). Without reflexivity the everyday conversations shaping our knowledge may do so in a manner which is not conducive to our personal ends or goals (Cunliffe, 2002a). Thinking more critically about our assumptions and actions enables us to engage in a more collaborative and responsive manner (Cunliffe, 2004). In order to find our own voice, the voice of others, and voices we may silence by our words and actions, we must be able to identify our assumptions and then be critically reflexive about those assumptions specifically focusing on areas of uncertainty and contradiction (Cunliffe, 2004). Dialogue permits us to observe our own experience and behavior through others (Raelin, 2012).

In a similar vein of argument Cunliffe (2002a) describes reflexive dialogue as the mechanism through which we become aware of our assumptions, our ways of talking, and our theories in action, which both shape, and are shaped, through our interactions with others. Taken for granted assumptions, and meanings, are challenged in an emancipatory and empowering manner (Raelin, 2018a). Reflexivity enables individuals to increase their awareness of the importance of their conversations and interactions with others (Cunliffe & Erikson, 2011). Achieving effective collective thinking requires actors to have outward curiosity (towards the group) and inward curiosity (to examine self) (Ringer, 2007). Raelin (2012) is adamant that collaborative action requires a dialogue where both parties are interested in listening to one another and in reflecting on other perspectives. This viewpoint positions both parties to wait until there is reflective and reflexive readiness on the part of the other. In other words, there is no power of one unless the

other allows it. Having said this, Realin (2016b) recognizes that change is influenced through new dialogue. Small steps of change are influenced through the leadership activity of critiquing everyday events and conversations (Cunliffe, 2002a). This means that, through the leaderful practice of focusing on changing meanings and interpretations of behaviors it is possible to change the behaviors themselves (Cunliffe, 2002a; Raelin, 2012).

Cronholm et al. (2013) make the argument that development of the clinic culture and mental models necessary for PMH implementation requires effective dialogue strategies within the team. Dialogue emerges through the responses and reactions that living beings have with each other on a day-to-day basis (Shotter, 1997; Raelin, 2018a). These day-to-day interactions, and purposeful dialogue with others, provide the mechanism through which organizational reality, shared meanings, recognition of differences, and identity construction emerges (Cunliffe, 2009; Ospina & Foldy, 2010). Nieuwboer et al. (2019) also support the importance of iterative relational skills in their work on clinical leadership and integrated primary care. The purposefulness of dialogue choices cannot be overemphasized as an important aspect of leadership. Leadership, and leadership identity, within self, within others, and between self and others is derived from all aspects of language including articulation, silences, and gestures (Cunliffe, 2002b). Thus, dialogic choices, identified through reflection and reflexivity, will impact the emergence of the NPNL and are a fundamental tool by which leadership and change can be enacted within the PMH.

Through this section of my literature review I have established that leadership emerges where several CoP come together, and porous boundaries allow individuals to move into new social

roles and practices across the PMH LoP. Further, even where the individual does not perceive themselves to be moving into a different, or new, CoP cultural items such as power, as manifested through dialogue, are moving across the CoP membranes. Shared meaning is formed through creation of language in the space between CoPs. The developing language will include evolving rhetorical strategies, responsive dialogue, and speech genres (Cunliffe, 2002b; Dunn, 1999). These arising forms of dialogue, including language choice, stories told, and non-verbal behavior and speech, by all actors in the environment, shape all aspects of culture including power, identity development, and perceptions of leadership (Somacescu, et al., 2016; Hersted & Frimann, 2016). Finally, I established that actors across the PMH LoP may impact organic CoP reproduction and adaptation through engaging in the dialogic tools of reflective and reflexive conversations. It is through these reflective and reflexive conversations that we are enabled to question our being and acting such that we are able to develop new ways of talking and acting (Cunliffe, 2002a). Therefore, it is important that my research explores how nurses recognize and influence their emergent leadership self in the LoP of the PMH.

SUMMARY AND CONCEPTUAL MODEL

Through my literature review I have established that although there is a large body of literature focused on leadership, there remains conflicting views regarding effectiveness of various models. Further, much of the empirical work has been done outside the PMH and generalizability of existing leadership models to the PMH has not been clearly demonstrated. I provided a brief overview of developing views regarding leadership theories and why the major leadership theories do not fit NPNL in the PMH. Specifically, I challenge those theories that contend leadership is restricted to an identified person in an identified position (Juntrasook et al.,

2013). I concluded the leadership theories section by presenting Raelin's leaderful model as a both a goal, and potential outcome, of NPNL in the PMH. I then explored the contextual issues impacting leadership in the PMH including nurse identity development within the PMH environment and physician – nurse power differential as it relates to nursing leadership in the PMH. Further, I established dialogue as an artefact of an existing CoP, a product of interacting CoP within a LoP, and an operational mechanism through which nurses may purposefully enact leadership in an iterative manner. The main themes I have explored in my literature review are organized in my conceptual model shown on the following page. My conceptual model, in turn, provides the framework for my empirical work.

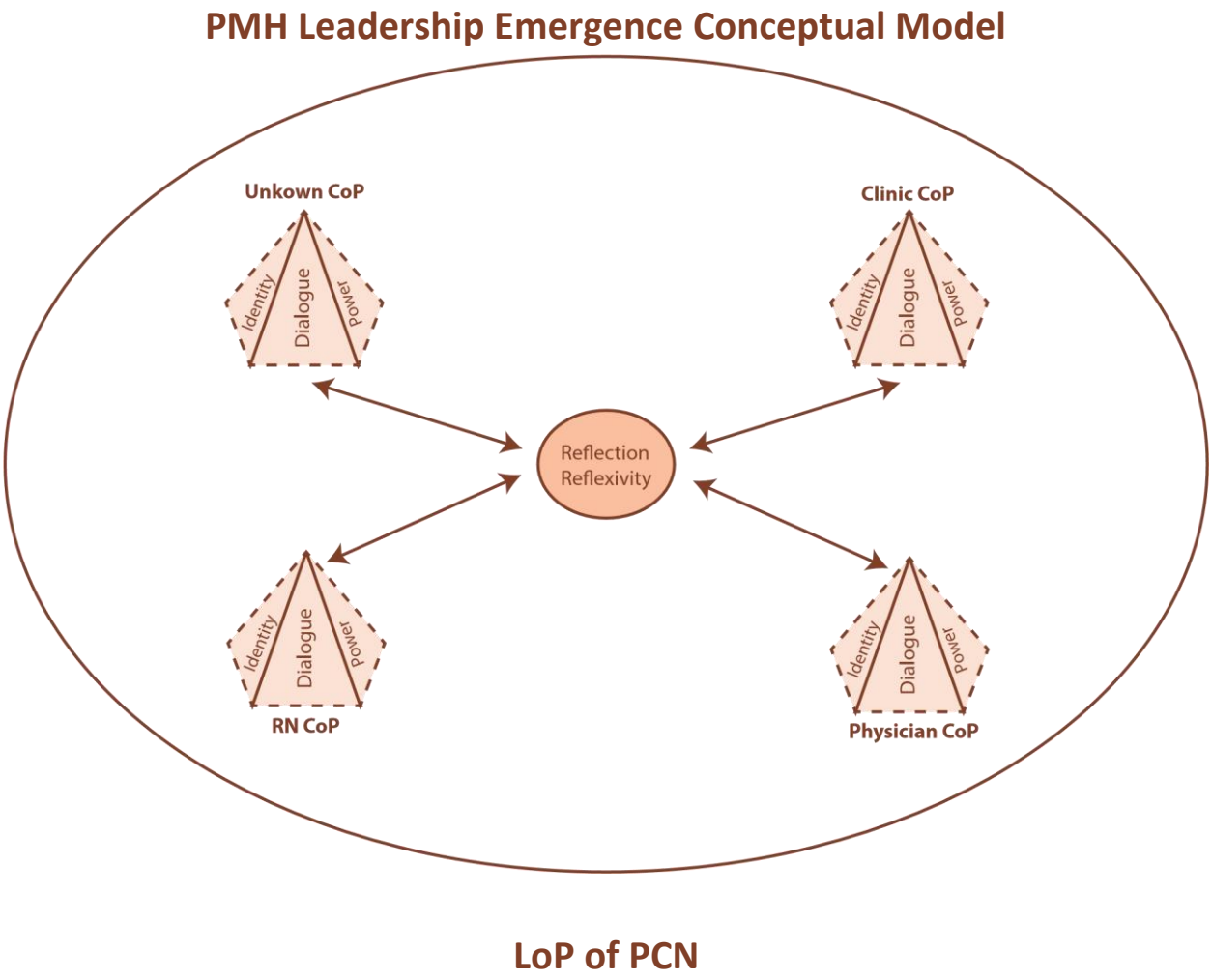


Figure 1 – PMH Leadership Emergence Conceptual Model

The pyramids in my conceptual model display three named CoP and an unknown (?) CoP. The named CoP (physician, nurse, and clinic) are typical in a family practice clinic in the PCN. However, it is expected that there will be one, or more, additional CoP depending on many factors such as size of clinic, any specialized services in the clinic, and if the clinic is a practicum location for physicians and/or nurses. Each CoP is a unique context and its membership has specific social roles and norms, and a body of knowledge. The social roles and norms, as well as the body of knowledge, are influenced by member identity, power, and dialogue. Dialogue has

been given a central, and prominent, role in my CoP pyramids as it is an artefact of an existing CoP, a product of interacting CoP across a LoP, and an operational mechanism through which other concepts, namely identity, power, and CoP knowledge are externalized. The CoP are porous, as indicated by the dotted lines on the outside of the pyramids in my conceptual model. This porosity allows members to move in and out of the CoP. It is important to remember that specific CoP permeability is in a constant state of change depending on the interaction and influence of identity construction, power dynamics, and dialogue. Further, each CoP may overlap with other CoP. I have not focused on this in my conceptual model as I want to focus on the space between the CoP. The arrows going to and from the CoP pyramids to the center of reflection and reflexivity indicate knowledgeability development. The concept of knowledgeability does not indicate full competence, as experienced by members within a CoP, but rather the skills which enable navigation across a LoP (Brown & Peck, 2018). Further, knowledgeability captures the complex relationships which interact between CoP within a LoP (Pyrko, et al., 2019; Omidvar & Kislov, 2014). The center oval captures the deliberation of reflection and reflexivity through which individuals, and groups, develop their knowledgeability. It is through this space of knowledgeability that leadership emerges across the LoP. Finally, the oval surrounding my conceptual model conveys the LoP of the PMH.

In the table below I summarized the key issues I identified in my PMH Leadership Emergence Conceptual Model. These issues form the foundation of my interview protocol

Key Issue	Occurs
Identity	Emerges through interactions both within a specifific CoP as well as in the space between CoP (or across the LoP of the PMH).
Power	Is embedded in hierarchical roles within individual CoP as well as between CoP. This affects the interactions within and between various CoP.
Knowledgeability	Emerges between multiple CoP across a LoP through rela tionship development, identity and sensemaking.
Dialogue	Is the mechanism through which identity and power are given meaning. Emerges from CoP across a LoP (i.e. is an artefact of practice). Is also a choice, or tool, to impact within and between CoP.

Table 1 - CoP Key Issues

Through developing knowledgeability of the various CoP, and purposeful dialogue management, the PCN nurse will be able to impact his or her identity to enact leadership. Further, through endorsement of a culture of continuous learning and development, rather than application of known best practices, the nurses within the PCN will be able to foster leadership-as-practice in themselves whereby non positional nursing leadership is enacted as best determined in a situation-by-situation basis (Raelin, 2016b). Reflection and reflexivity are the learning and development tools, or microscope, we will use to take a closer look at identity, power, and dialogue as the interacting constructs of leadership emergence. Further, reflection and reflexivity, are the mechanism through which the nurse may recognize, and influence, his or her emergent leadership self in the PMH. Finally, where NPNL is emerging effectively it will more readily enable the 4 C's of Leaderful practice namely collectivity, collaboration, concurrence and compassion.

3 METHODOLOGY

In Chapter 1, I established a clear need for leadership to achieve the desired outcomes of PMH transformation. Unfortunately, there is inadequate evidence on how to develop and implement this required leadership, and what exists is focused on physicians. Both within the PMH literature, and my personal experience, this has had limited results. A gap in the literature, and a substantially untapped resource within primary care, is the engagement of nurses in non-positional nursing leadership (NPNL) within the PMH.

Chapter 2 considered literature relevant to the exploration of non-positional nursing leadership (NPNL) enactment in PMHs. Although there is a large body of literature focused on leadership, there remains conflicting views regarding effectiveness of various models. Further, much of the empirical work has been done outside the PMH and generalizability of existing leadership models to the PMH has not been clearly demonstrated. I established why the major leadership theories do not fit NPNL in the PMH. Further, I presented Raelin's leaderful model as an extension of effective NPNL in the PMH. I briefly explored the contextual issues affecting leadership in the PMH, including nurse identity development within the PMH environment and physician-nurse power differential as it relates to nursing leadership in the PMH. Finally, I presented dialogue as both an artefact of NPNL in the PMH, and at the same time, a contextual influence towards NPNL in the PMH. The concepts of multiple CoP, both known and unknown, interacting across the LoP of the PCN was used to demonstrate the endorsement of the PMH as an environment of continuous learning and development, rather than a setting for application of known best practices. It is posited that this framework will enable the nurses, within the PCN, to

foster leadership-as-practice in themselves whereby NPNL is enacted as best determined in a situation-by-situation basis (Raelin, 2016).

Chapter 3 outlines the philosophical perspectives underlying the methodological choices I have made to explore how non-positional nursing leadership is understood, and enacted, by registered nurses within PMHs in Palliser PCN. I explore philosophical concepts as they relate to the ontological and epistemological choices I have made in my thesis. I explain my research methodology choices and I then justify my choice of action research (AR) and most specifically a critical interpretivist mode of AR. Next, I describe my research participant selection. I describe the cycles of my action research including my data gathering methods and analysis choices used for each cycle. Finally, I briefly outline the ethical considerations of this form of AR.

PHILOSOPHICAL PERSPECTIVE

Consciously, or unconsciously each of us aligns with a metaphysical system, or paradigm, that helps us understand the world. Exploring this understanding raises question about how we understand the nature of reality or ontology (Jacquette, 2002). The ontological position of realism posits a shared single social reality. This ontology views truth as a single entity whereby facts exist and can be revealed (Easterby-Smith, et al., 2012, p. 19). In contrast, relativism posits several social realities, contextually determined, and occurring simultaneously. This ontology views many 'truths' existing whereby facts depend on the viewpoint of the observer (Easterby-Smith et al., 2012, p. 19). Immanuel Kant laid the groundwork for this perspective when he

made the distinction from objectivism stating that human knowledge is ultimately based on understanding and therefore human claims about nature cannot be independent of inside-the-head processes of the subject (O'Hagan, 2009). Finally, the ontological position of nominalism posits that social reality does not exist outside of the labels and names which we attach to experiences and events (Easterby-Smith, et al., 2012). This ontology views truth as not existing; facts are all human creations (Easterby-Smith, et al., 2012, p. 19).

Epistemology refers to the ways we inquire, or come to know, the nature of the world (Easterby-Smith, et al., 2012, p. 17). All research, as a mechanism for knowing, falls within one of the two main epistemological perspectives of knowing, positivism or constructivism (also known as interpretivism) (Hinchey, 2008). Positivism defines knowledge as existing independently in the world such that it can be discovered, is verifiable, stable, and universal (Hinchey, 2008). In contrast, constructivism defines knowledge as being dependent on human perception, and thus dependent on culture, history, and belief (Hinchey, 2008). Hinchey (2008) goes on to say that within constructivism multiple realities exist simultaneously.

Paradigms are deeply rooted in our professional training and reinforced through the communities in which we work (Creswell, 2013). Medicine, and to a lesser degree nursing, are both deeply rooted in the natural sciences where knowledge consists of facts discovered through controlled experiments (Hinchey, 2008). At the beginning of my career, I held fast to my positivist beliefs and in fact many of them remain highly ingrained such as the universal cardiovascular need for potassium and sodium balance. That said, I became less faithful to the positivist paradigm as I

moved through my career and studies first in mental health counselling and then in education. The shortcomings of a positivist ontology become bluntly evident during crises or family counselling when the same event is described (interpreted) by each participant. The interpretation is quite likely to be vastly different and yet is no less possible and/or credible. Moving the client, or student, towards acceptance of multiple emerging realities and then working within those dynamic realties for optimum, unique, understanding and functioning is much more effective than a prescriptive external solution. It is impossible for the nurse, or other actors within the PMH, to escape the influence of every individuals' emerging experience on perception. Further to this, each emerging perception will dynamically influence self and others. It is through my iterative professional training and experience that I am shaped to take the action researcher lens of nominalism in terms of what reality is and constructivism in terms of how to explore that reality.

My methodological choices within this research are based on the ontological and epistemological elements of nominalism and constructivism, respectively. A positivism approach is not appropriate as it would present leadership as existing in a way that can be taught, learned, and implemented in a generalizable manner. Further a relativism approach would suggest that leadership exists we simply need the wisdom of the group to identify the various forms of it. Pragmatism, is attractive as it focuses on the practical. Further, pragmatism positions words and thoughts as tools for problem solving and action. However, pragmatism positions truth as knowable, or out there, and does not recognize the construction of previously unknown knowledge. Nominalism reflects that leadership does not exist as an entity to be defined; however, individuals may strive for descriptions of leadership to help them engage in

understanding, or sense-making, of their situation in efforts to both gain new insights and participate in action in a dynamic and ongoing manner (Easterby-Smith, et al.; 2012). It is through development of personal understanding or sensemaking, of leadership-as-practice that each nurse will develop not only pragmatic knowledge (what currently is) but perhaps more importantly will be able to conceive of what could or should be. A future focus will enable each nurse to strive for a new, and possibly more effective, reality. This research process is supported by Raelin (2018a) who states that effective study of leadership will include exploring the emergent realities of leadership. Constructivism respects the practice-based emergent understanding, and knowledge, of the nurses as they collectively and collaboratively explore their leadership within their respective PMHs.

For me, nursing leadership in the PMH is part of the ethical responsibilities every nurse accepts when he/she is granted the privilege of a nursing license. As outlined above it is through leadership that the PMH will be achieved, and in turn, lead to improved patient outcomes. I believe that through reflection and reflexivity each of us is able to interrogate and evaluate our respective practice, and have the opportunity to improve what we are doing, and influence others (McNiff, 2013).

METHODOLOGY

The third and final component of a paradigm is methodology. Methodology helps us define how we gain knowledge about the world. There are several methodologies to choose from within the interpretivist or constructivist approach depending on the focus of enquiry of the research. First, I outline the suitability of action research as a methodology to bring about change in leadership

practice within the PMH (Anderson et al., 2015). Then I describe a selection of action research approaches, each with a different focus on power, social reform, community development and/or oppression, and their suitability for my research (Greenwood & Levin, 2007).

I am engaging in action research (AR) both as a requirement of my DBA and based on the fitness of AR to my area of research interest. The central characteristics of action research (AR) are articulated by Argyris et al. (1985) as follows:

- AR involves change experiments on real problems in social systems and seeks to provide assistance,
- AR involves iterative cycles of problem identification, planning, acting, and evaluating,
- The intended change in AR typically involves re-education. Re-education refers to changing well established patterns of thinking and action. Effective re-education requires participants to help diagnose, fact-find and free choice to engage in new kinds of action.
- AR challenges the status quo from a participative perspective.
- AR is intended to simultaneously contribute to basic knowledge in social science and to social action in everyday life.

NPNL within the PMH is suitable for action research as it is (a) a real event which is best managed in real time, (b) provides an opportunity for both action and learning, and (c) can contribute to theory of PMH transformation and specifically knowledge of the nurses' leadership role in this environment (Coghlan & Casey, 2001). AR offers the opportunity to engage in research that is of immediate relevance to the practitioners (Johansson & Lindhult, 2008). AR offers an opportunity for the participants to engage in an iterative process of diagnosing and acting to positively impact the transformation of the PMH in which they work (Anderson et al.,

2015). Further, AR offers the opportunity for the nurses to democratically participate in shaping their own questions, learning, and development, which some authors believe produces better quality social research than that arising from expert-led research (Greenwood & Levin, 2007). Finally, the collaborative and collective properties of AR make it an appropriate methodology platform from which to consider leaderful practice as a stretch goal and/or outcome of NPNL in the PMH (Coghlan, 2007).

Research investigating leadership-as-practice (LAP) is not aligned with a single methodology. Rather, this type of research seeks a type of inquiry that is lived, or true, for those that are living it (Raelin, 2019). Raelin (2019) goes on to say that looking at leadership under a praxis-oriented lens subsequently leans towards interpretive forms of inquiry such as discursive, narrative, ethnographic, and/or aesthetic approaches. A fulsome study of LAP considers all aspects of dialogical and practice activity occurring, and as such, lends itself to consideration of the artefacts, technologies, physical arrangements, language, emotions and rituals within the practice (Raelin, 2019). I must address the breadth of LAP, and action research, through choosing an approach to action research which is both feasible within my thesis constraints and likely to lead to change and improvement within the PMH.

The first methodological approach I have considered is action learning. Action learning is focused on programmed instruction on a specific topic (Anderson et al; 2015). Subsequently, action learning is not appropriate for my research as we do not know enough about nursing leadership within the PMH to provide this type of instruction. Next, I considered appreciative

inquiry. Appreciative inquiry is appealing in that it focuses on the positive capabilities of individuals and organizations (Anderson et al., 2015). However, this mode requires commitment from large numbers, and different groups, within the organization. This might see research that includes the physicians, and clinic team members, across all 42 PMHs in Palliser PCN. This is not a feasible research project within my resources.

Next, I carefully analysed participatory-action-research (PAR). PAR is an attractive methodological choice for researching NPNL in the PMH as it supports community participation in efforts to gain a more accurate and authentic picture of social reality (MacDonald, 2012). However, for the novice researcher PAR is challenging due to its diversity of meaning in the literature, the inclusion of the community members throughout the research, as well as the need to address power imbalances and establish egalitarian relationships among the participants and researcher (MacDonald, 2012). Time constraints, political constraints, and community access make PAR an unsatisfactory methodological choice for my research.

Ethnography was also considered as a potential methodology. The key principle of ethnography is that the researcher must become part of the group to understand the meanings that people give to their behaviour and that of others (Easterby-Smith, et al.; 2012). This is not feasible for me, nor would I be accepted by the participants, in this manner. Furthermore, conventional ethnography does not critique the situation or consider alternatives (Johnson & Duberley, 2000). This does not lend itself to an interventionist perspective and therefore, ethnography is not a suitable methodology for my investigation.

Another methodology I considered was narrative-based research whereby the research focuses on the stories participants tell about their experiences (Easterby-Smith, et al.; 2012). Narrative methodology is appealing as it focuses on what research participants tell in their stories as well as how participants tell their stories (Juntrasook, et al., (2013). However, narrative analysis does not give room to consider what informs, prefigures, and predisposes the participant narratives (Thorpe & Holt, 2008). Given the importance of context, identity, power, and dialogue within the PMH, narrative methodology is not suitable for my research.

My methodology embraces a critical interpretivist mode of AR. Critical methodology, through analysis of the current situation, enables both understanding of how the current situation developed and openness to the possibility of a different outcome (Johnson & Duberley, 2000). Critical theory is suitable for investigating NPNL as it seeks to explore the motives, and impact, of powerful groups and individuals (Easterby-Smith, et al.; 2012). Critical AR, with its focus on questioning that which has formerly been taken for granted, will surface questions regarding power: who has power, how they use that power, and who benefits and/or is harmed by the power (Hinchey, 2008). Critical research is the specific mode of action research I have focused on as it provides a framework, or space, to assist less powerful groups (nursing in primary care) to analyse, and problematize, their current situation and identify change strategies (Carr & Kemmis, 2003; Hinchey, 2008). I value an emancipatory mindset, whereby the individual, or group of individuals, accept responsibility to free themselves from real, and self-imposed, oppression (Freire, 1995). This mindset is shaped through my life journey, both personally and

professionally, whereby I have been driven to set, and achieve goals. I do not believe circumstances to be oppressing, but rather challenging, and amiable to be shaped and changed by my cognition, emotions, and behaviour. However, I recognize this mindset could be perceived as victim blaming, and further has an inherent risk of disempowerment of the nurse if he or she does not focus on his or her sphere of control but rather focuses on another to release power to him or her. Through this strong constructionism approach to critical action research I hope to come to understand how the nurses create structures to help them make sense of what is going on around them (Easterby-Smith, et al.; 2012). Further, I believe, that through this action research journey that the nurses will come to understand that, although I am the positional leader of the company, and the leader of this research, I do not have the answers to help each of them unlock their NPNL. I will strive to have the participants understand that they are the experts on their own NPNL enactment within the PMH.

I acknowledge that, my research aligns with a feminist paradigm in that I am a female researcher, striving to conduct transformative research that recognizes issues such as power dynamics in the heavily gendered professions of nursing and medicine (Creswell, 2013; Thorpe & Holt, 2008). Additionally, my interest in the subjective experiences of the participants is aligned with a feminist perspective (Easterby-Smith, et al., 2012). A goal of feminist research is to establish collaborative and non-exploitive relationships (Creswell, 2013). I argue that this goal of feminist research, in the context of the action research in which I am engaging, is a stretch goal and does not realistically acknowledge the current environment nor the power of the nurse participants to engage in change.

Eubank et al. (2012) state that to effectively develop leadership the contradictions between espoused leadership and implicit leadership must be explored. Such exploration requires the use of language and dialogue. My role, as the researcher, is to activate the research by, and for, the nurses whereby they are engaged in reflection and reflexivity, specifically considering their dialogue in use, regarding improving their leadership skills within the PMH (Johansson & Lindhult, 2008). Further to this, leadership must be contextually 'grounded' to be relevant; the context can only be explored through language and dialogue. Critical action research focuses attention on use of language and dialogue as people create their own meanings (Easterby-Smith, et al., 2012). An interesting, and potentially problematic phenomenon to note is the discourse impact of using the term leader to describe an actor (Raelin, 2016a). As I needed to find a conversation starter for my interviews, I chose to use the term leader and explore the participants understanding of this term. Dialogue is a necessary tool of the critical interpretivist mode of action research as organizations, and the people within them, typically require active facilitation such that members begin to understand the value of sharing leadership and distributing leadership functions among a team (Raelin, 2005). Further care, and attention, must be given to assist a team to explicitly consider their team dynamics. Depending how quickly leaderful practice emerges the 'facilitator' would gradually back out of an active role (Raelin, 2005). In their work on empowering nurses to lead interprofessional collaborative practice, Embree et al. (2018) found significant variability in nurses' readiness, and competency, to engage in leadership within the practice environment. This finding assists in making the case regarding the appropriateness of AR for my area of interest since AR is undertaken with purposeful efforts of collaboration and co-inquiry (Coghlan, 2007).

In conclusion critical AR is a suitable mode of inquiry for my research because it recognizes nursing leadership within the PMH as being emergent processes. Further, nursing leadership is understood, through critical AR, to mutually influence the various CoP in a specific PMH and across the landscape of the PCN. AR will offer myself, and the participants, the opportunity to understand the nurses' rationale for what they are currently doing and why they are doing it, along with exploration of opportunities to change what they are doing. Through the act of doing the research all of us are likely to change as we engage in unravelling experiences within the PMH(s) and critically reflecting within, and between, ourselves.

RESEARCH PARTICIPANT SELECTION

The target population of my research was the sixty-five registered nurses working in 42 clinics within Palliser PCN. I sought ten research participants through an open call via an email from myself and a posting on the PCN employee web-based discussion board. I did not place any limitations on years of experience or clinic Health Home Optimization (Appendix 1) score. There could be a perception that years of experience impacts leadership either positively or negatively. Higher Health Home Optimization scores may indicate clinics more inclined to be PMHs and subsequently a greater likelihood of engaging in effective leadership. Clinics within the Palliser PCN have variation including one physician to 8 physicians, clinic manager or no clinic manager, urban or rural, female physician(s) or male physician(s), multiple PCN clinical employees or single PCN clinical employees. I selected participants to reflect a minimum of five unique clinics within the PCN.

This convenience sample of participants are registered nurses who worked for the Palliser Primary Care Network at the time of the interviews (February to March 2019). Participants self-selected from an email, a discussion board post, and finally by the researcher being available to speak with potential participants face-to-face at a learning event. Several potential participants voiced a lack of time, lack of interest in research, and lack of leadership expertise, as rationale to not volunteer to participate in my research study. However, once potential participants asked, and I answered, questions around (a) the need to have experience in research, (b) the need to have pre-existing expertise in leadership, and (c) any expectations of taking on formal leadership roles there were more than 10 volunteers. I felt that some of these questions from potential participants were to establish trust and credibility in myself as a researcher (Creswell, 2013). The first 10 participants, meeting my selection criteria, were selected. Ten participants allowed for the development of a rich description of the RNs experience in NPNL within the PMH (Creswell, 2013).

Participants reported from 1-36 years of nursing experience and from 1 to 10 years of primary care experience. No participants had higher than a bachelor's degree in nursing. Participants came from a variety of backgrounds including acute care, emergency care, long term care, addictions and mental health, public health, and corrections. Participant details are outlined in the below table.

Participant	Highest Level of Post-Secondary Education	Years in Nursing	Years of Primary Care Nursing	Previous areas of Nursing Experience	Clinic Team
001	Bachelor of Nursing	14	10	Emergency, Geriatrics, Psychiatry	Physician, MOA, BHC and RN
002	Bachelor of Nursing	5	2	Addictions and Mental Health, Sexual Health, Public Health	6 RNs, 8 Physicians, 1 BHC, 10 office personnel
003	Bachelor of Nursing	15	6	Oncology, Medical - Surgical, LTC	6 RNs, 8 Physicians, 1 BHC, 10 office personnel
004	Bachelor of Nursing	9	2	Worked 1 year on a medical-surgical unit (extended mat leave)	1 physician, 1 RN, 2 office personnel
005	Bachelor of Nursing	8	1	Emergency, Medical-Surgical, Pediatric ICU, pediatrics	1 physician, 1 RN, 1 office personnel
006	Bachelor of Nursing	36	6	LTC, post-surgical, urban health clinic (native affairs), radiation – oncology, rural nursing	1 physician, 1 RN, 2 office personnel (switch office with another 2)
007	Bachelor of Nursing	10	3	Geriatrics, medical, medical-surgical, psychiatry	3 office personnel, 4 physicians, 2 RNs
008	Bachelor of Nursing	12	2	Cancer care, home care, organ transplant	1 physician, 1 RN, 1 MOA
009	Bachelor of Nursing	12	4	Medical-Surgical, Corrections	3 office personnel, 3 physicians, 2 RNs
010	Bachelor of Nursing	1	1	N/A	1 NP, 1 BHC, 4 RNs, 5 physicians, 7 office personnel

Table 2 - Research Participants

RESEARCH CYCLE & METHODS

It is important to note that the action research cycle includes dynamic cycles of conceptualization, action, experience, reflection, and reflexivity (Johansson & Lindhult, 2008). Reflection and reflexivity were tools I used to engage in my AR and were also tools I engaged

on, or about, with the nurse participants in my research. As demonstrated in the below diagram my research involved considering the context of my research (the respective PMHs in Palliser PCN) as well as the purpose of my research (accelerate enactment of NPNL to further PMH transformation). Further to this, my research was contextually sensitive to leaderful practice as an extension of effective NPNL. Namely I endeavoured to interact in a manner that was collaborative, collective, concurrent, and compassionate (Raelin, 2013).

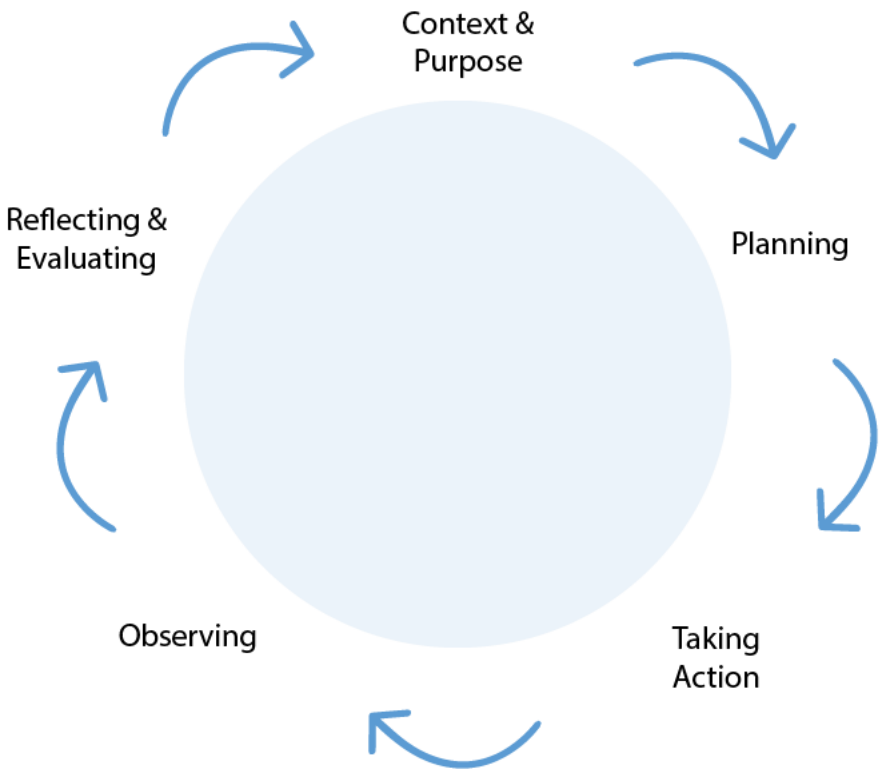


Figure 2 – Action Research Cycle
Adapted from Coghlan & Brannick, 2014

At the beginning of my research, I believed that I would engage in one cycle of action research during my thesis. I have reconceptualised my initial thinking and now consider each step of my research a cycle, or spiral, of action research. This cognitive shift is reflective of my progression as a practitioner-researcher. Each interaction with my participants brought me, and to a lesser

degree the participants, through the steps of considering the context, planning, taking action, observing, reflecting and evaluating. Figure 3, below, shows each cycle of my research and further indicates that the cycles will be ongoing as there is no end destination of NPNL. Each event or experience of NPNL will be dependent on the specific actors at a specific juncture in time.

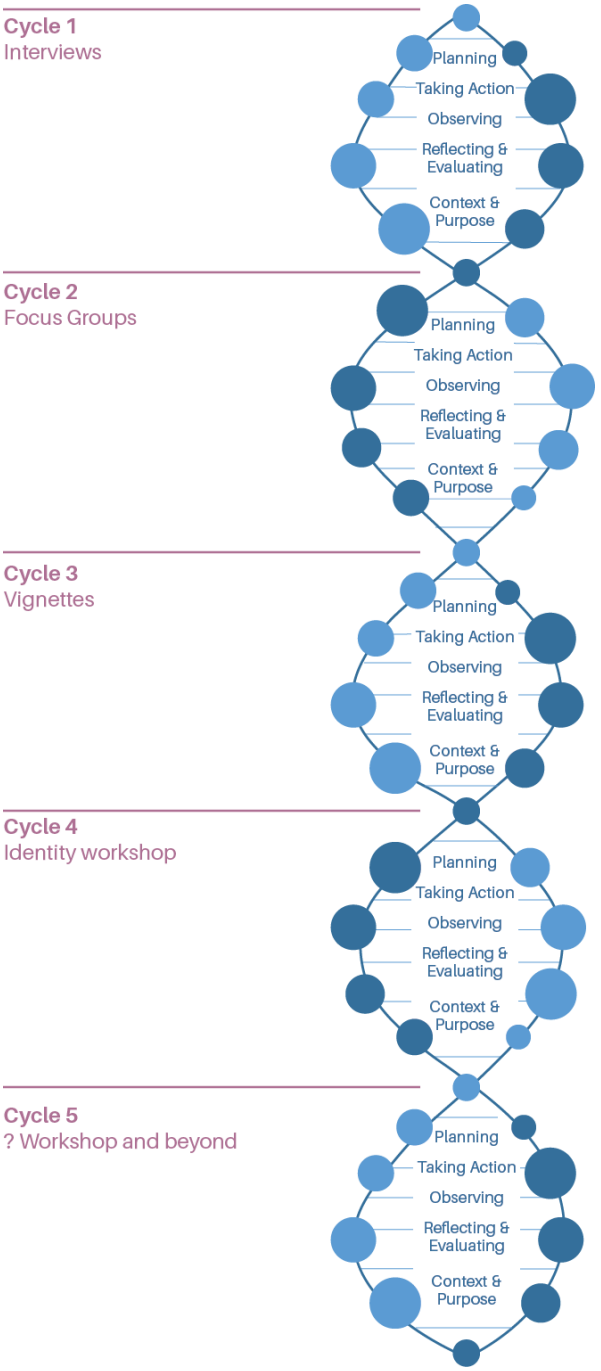


Figure 3 – Action Research Helix
Adapted from Coghlan & Brannick, 2014

Next, I will review each cycle of my research and outline the methods I used to collect and analyse the data.

Cycle 1: The initial phase of my research explored NPNL in the PMH as perceived and described by individual nurses within PMHs. I chose individual interviews, over a group interview process, as individual interviews have an advantage in that they often encourage participants to speak more freely. The pool of 10 research respondents participated in semi-structured interviews. The participants were offered to do the interviews at a time and place of their choosing. Each participant chose to do the interviews at my office, face-to-face during regular business hours. The interviews were held with each participant individually.

As identified by Easterby-Smith, et al., (2012) the goal of the qualitative interview is to illicit the participants viewpoint regarding the topic at hand as well as why the individual holds the particular viewpoint. Initially, my interview protocol consisted of a broad, open ended question regarding participant understanding of the term leadership, and leadership enactment within the clinic. However, as identified in Chapter 2, Table 1, my literature review uncovered specific issues which warranted investigation during the interview process. The key issues identified were identity, power, knowledgeability and dialogue. Subsequently, I refined my semi-structured interview into 4 open-ended questions. The interview protocol is found in Appendix 2.

Reflection and reflexivity are the tools my research participants used during the interviews to consider the elements which emerge within, and across, CoP. These elements, outlined in table 1, include identity, power, expertise and dialogue. Using a semi-structured approach, as outlined in the interview protocol (Appendix 2), allowed me to ask specific questions such as “how would

you describe how leadership happens within the PMH where you work?" while still allowing the participants to shape the conversation and follow their own line of thinking. The flexibility of my interview protocol enabled me to uncover unexpected data (Hinchey, 2008). It was imperative that I design questions that were not leading. Rather, the interview was designed to engage the nurses in a reflective and reflexive experience. This interview method allowed the nurses to recognize their emergent leadership selves in the PMH.

I kept a written copy of the protocol during the interview as (a) a mechanism to ensure all research questions were asked/answered, (b) a mechanism to keep track of interesting words, phrases or statements the candidate used such that I wished to explore further during the interview, and (c) as a key word backup in case a problem occurred with the recording device. These transient documents were destroyed following the interview once the recording had been checked and saved. Of note, it became clear after the first interview that the participants struggled to answer questions regarding identity. This question needed to be reframed such that I asked the participants to imagine they were meeting a stranger and describing themselves to the stranger, further probing questions regarding how this identity came to be formed were then required. Rapport was easily established, and effective interviewing technique was employed related to my background in mental health counselling. Each interview took approximately 1 hour. The interviews were audio recorded on my phone and then saved to a secure drive in my workplace and on an encrypted thumb drive. I transcribed the interviews myself since this would assist me in engaging with the interviews in a thorough and robust manner.

It was important during the interviews to remain conscious of the type of interview I was engaging in with the participants. There existed a risk that I could move into a therapeutic relationship and thereby entice the participants to engage in unguarded confidences (Burman, 1997). As Kvale (2006) reinforces, because I am more comfortable with therapeutic interviewing, over research interviewing, I needed to remain aware of potential ethical issues related to a therapist versus researcher role and address these issues if they arose. Throughout the interviews I remained conscious of my role and purpose in engaging with the participants. I internally held myself accountable to the boundaries between these roles. I found this responsibility similar to the effort required to maintain the boundaries between friend and therapist roles. This requires active internal critical dialogue and a high degree of personal accountability.

Further to this it was important that I remain conscious and authentic when considering the power imbalance in the research interview. Kvale (2006) reminds us that the research interview is not a mutual dialogue process in that the researcher is seeking understanding through use of the participants' thoughts and articulation. The research interview may be considered a one-way dialogue controlled by the researcher up to and including the point of interpretation (Kvale, 2006). However, the semi-structured format of the interviews did allow flexibility such that participants' ideas could be pursued, clarified, and expanded upon (Gordon et al., 2015). Further, the open-ended questions allowed the participants to take the conversations in a direction that was meaningful to themselves. The interview guide was used more as a checklist to ensure all interview questions had been asked towards the end of the interview rather than a

directive guide throughout the interviews. The interviews lasted from forty-five to seventy-five minutes each.

Immediate transcription was attempted; however, workload in relation to the pandemic impaired this plan and necessitated a gap in conducting the interviews and transcribing the interviews. However, staying engaged with my interview topic has not been a challenge as I am invested in the topic from several angles including as a mechanism to achieve my organizational objectives, as a woman, as a nurse leader, as a leader and as a step along my DBA journey. Feelings of being overwhelmed by the data have waxed and waned throughout this process. I was surprised when I began transcribing the first interview that I could not keep up to the conversation and needed to stop and reverse the interview frequently. Subsequently I used an audio program which allowed me to slow the speed of the conversation and eliminate the need to stop and reverse the recording. Each 1-hour interview took approximately 3 hours to transcribe. As such, at the end of each transcription I felt a deep connection to the participants' insights into leadership in their respective PMHs.

I did not refresh myself on my literature review, or research framework, before moving onto my initial interview coding. The rationale for this decision was to permit emergent or in-vivo coding to happen organically versus using pre-existing codes from the literature (Creswell, 2013). The words and phrases of the participants formed the basis of this round of coding (Linneberg & Korsgaard, 2019). The transcribed interviews were photocopied onto colored paper (each color representing a specific participant). The interviews were then coded and cut apart to be separated

into piles of like codes. This first round of coding allowed me to create a gestalt of the data (Linnegerg & Korsgaard, 2019). Each code was then placed in a freezer bag so I could easily recognize the codes and consider how like codes could be further themed.

At this point I loaded the transcripts into Nvivo qualitative data software. The Nvivo software was helpful as it enabled me to classify and sort the data, which enabled me to examine the data in a structured manner. The initial inductive coding resulted in 40 different codes (Appendix 3). Some of the data was discarded as it did not fit into a code and was determined to be irrelevant to this research project (Linneberg & Korsgaard, 2019). The freezer bags (codes) were then grouped into like ideas, informed by the literature, to form themes. This information was also loaded into the Nvivo software. I reread the interviews through a critical discourse analysis lens which enable me to consider the data with closer consideration of power and persuasion within the PMH context (Easterby-Smith et al., 2012).

It is important to remember that I have constructed my own reality from what I heard the nurses telling me. This was an abductive process for me as I would refer to the interview data, my analysis of the interview data, and then refer to the literature for areas of congruence and/or lack of congruence to influence my next steps. Xu and Zammit (2020) described this integration of inductive and deductive coding as desirable as it offers a balanced and comprehensive view of the data. Revisiting the theory led me to develop theory-driven codes while at the same time feeling the tension of data driven codes extracted from the raw interview data (Braun & Clark, 2019). As I became more familiar with the data, themes gradually emerged linking what seemed

disconnected codes into a LoP. This process pulled me from a state of being overwhelmed by the data to seeing the connections between the nurses' experience and the literature. This process of data analysis, literature review, and researcher reflection took approximately 8 weeks until a point of data saturation, whereby I could not identify any further coding in my interview data (Tuckett, 2005; Xu & Zammit, 2020). I have included quotes in my analysis for both illustration and validation purposes. A further mechanism I have used for maintaining rigour in the analysis has been through the formative debriefing process with my thesis supervisor. This process has enabled my supervisor to question my interpretations, provoke my critical thinking prompting alternative and additional perspectives and explanations (Morse, 2015). The codes, and linked coding examples, are reported in Table 3, Chapter 4.

From the individual interview findings, I created a visual metaphor. The metaphor presents the dimensions of non-positional nursing leadership in the form of a flower. The visual metaphor allowed me to reconstruct the nurses' abstract ideas of their leadership into a more concrete and familiar form of knowledge (Schwartz, 2020). Through creating an anchor to their unique experiences, the NPNL flower metaphor enabled the participants to feel connected, and thereby dialogue, more freely. Further, the visual metaphor was an effective mechanism to capture the process of leadership enactment, as well as the emotions and relationships surrounding the enactment (Schwartz, 2020).

Cycle 2: I presented the results of the interviews, in the form of the visual metaphor, to the research participants via a virtual focus group. I chose the focus group format as it (a) allowed me a mechanism to speak with all the nurse participants at once, (b) encouraged spontaneity

among the participants, and (c) provided a safe and social environment for the nurses to express their views and consider the social process of leadership (Cyr, 2019; Sim, 1998). Use of the NPNL flower metaphor provided a mechanism through which the participants were encouraged to slow down their thinking and engage in a deeper form of reflection and discussion (Schwartz, 2020).

The focus group method allowed the nurses to question the metaphor, experiment with different dialogue choices, and consider how they might use the metaphor to guide their actions and thinking around leadership (Anderson et al., 2015). The participants used dialogue to critically reflect on the analysis of their individual leadership interviews. The participants discussed leaderful practice and its relationship to current and/or future NPNL. Through a process of focused and purposeful dialogue the nurses explored their truth and understanding of both their current leadership role in the PMH as well as how they might impact PMH transformation in the clinic in which they are assigned (Easterby-Smith, et al., 2012; Raelin, 2012).

As I served as both the moderator and the researcher it was important that I strike a balance between being active and being passive during the focus group (Sim, 1998). I endeavoured to achieve this balance through articulating to the group, and holding myself accountable, to not be the expert in the focus group but rather a collaborative learner with the participants (Sim, 1998).

My primary data collection from the focus group was the notes I took during, and immediately following, the focus group. From my notes I noted the nurses cognitive and emotional responses to the NPNL flower metaphor. In particular, I noted an overall sense of enthusiasm and affinity

to the metaphor as a reflection of the nurses' experience. Second, I noted the nurses points of disagreement and consensus building related to the NPNL flower metaphor. I noted both the verbal and non-verbal communication the nurses used to talk about their present-day experience and the future on NPNL as a PMH transformation vehicle (Sim, 1998). I used my notes to capture exceptions among the nurses' overall enthusiasm for the metaphor and confidence that they could use the NPNL flower to capture, reflect, and improve their leadership-as-practice. I audio recorded the focus group so that I could refer back to it to confirm participant statements if required.

In summary the focus group served two purposes. One purpose was confirmation of the interview analysis. In other words, did the NPNL flower metaphor ring true for the participants. The second purpose was to further explore the nurses' perceptions of NPNL as they dialogued with each other in a group setting regarding how they would use the flower to further grow their NPNL.

Cycle 3: In cycle 2 the participants engaged in a leaderful focus group during which they critiqued the results of the initial interviews. The results of the initial interviews were introduced to the nurses through the NPNL flower metaphor. I used the metaphor to engage the nurses in thinking and talking about their current leadership-as-practice.

For Cycle 3, the nurses were asked to engage in a homework assignment between the focus group and the workshop during which they would capture NPNL experiences from their home clinic. As nursing is a reflective profession nurses have experience in journal writing. The

nurses voiced concern about the labour required for journal writing. A vignette method was chosen to capture the as-practice experiences as it requires minimal labour for the participants related to being focused on a brief description of a brief interaction. In efforts to help the nurses remain mindful of the NPNL flower dimensions both within themselves and other actors in their respective PMHs the participants were provided 3 postcards reflecting different states of the NPNL flower. The postcards reflected a wilted flower, a growing/healthy flower, and a robust/propagating flower (Appendix 4). The nurses were asked to identify, and briefly reflect, on a situation, or incident which they observed, or were involved in their day-to-day practice. The postcard vignettes were submitted to me 2 weeks later (Appendix 5).

I analysed the postcards through the following process:

1. I sorted the submitted vignettes into groups reflecting the 5 dimensions of the NPNL flower. Related to the size of the research group and further the size of the PCN, it was relatively easy to identify individual actors in the submitted vignettes. Further to this, I was concerned that the open, supportive, and positive characteristics I had seen, among the participants, in the focus group might be negatively impacted if I chose one of the vignettes to focus on during the workshop.

2. I chose to combine like vignettes into master anonymous vignettes reflecting a particular NPNL dimension.

3. Several of the vignettes were focused around identity. Additionally, identity was identified as a substantial challenge during the cycle 1 interviews. I aggregated the submitted identity vignettes to form a composite master identity (Appendix 6) vignette.

4. The same process was used to form a master power vignette (Appendix 7).

The master vignettes formed the basis of the cycle 4 workshop.

Cycle 4: Cycle 4 consisted of a workshop, focused on a master vignette (Appendix 6), with all nurse participants. A workshop method was chosen to provide an environment whereby participants are expected to actively participate, influence the direction of the content and

process and practice the dialogic skills of critical reflection and reflexivity (Orngreen & Levinsen, 2017).

The workshop was structured around the flower of NPNL and as such used critical reflection and reflexivity to: (a) consider how each nurse might increase NPNL enactment, (b) consider the impact of NPNL on PMH transformation, (c) consider how this type of structured development could lead to leaderful practice, and (d) consider the experience of participating in the research project itself. As outlined above, critical theory has a role in my research as the nurses and myself begin to overcome constraints that have been implicitly and/or explicitly placed on the nurses' leadership in the PMH (Creswell, 2013). The workshop discussion involved debate as participants put forth competing ideas (Coghlan, 2001). Buchanan and Badham (1999) state that such debate provides useful data and is an important part of learning and change as ideas are exposed to public scrutiny.

Similar to the focus group I had to balance the role of clinician (influencing the dialogue and reflexivity) and ethnographer (capturing the data) (Orngreen & Levinsen, 2017). The literature is sparse regarding data collection and analysis from a workshop method. My data collection from the workshop was very similar to my data collection from the focus group. I kept field notes during the workshop such that I noted specific points of agreement, excitement, disagreement, and concern among the participants as they interacted with the master identity vignette (Appendix 6). In my notes I indicated where participants' body language supported what they were saying (e.g., animated facial expression and posture when talking about

enthusiasm for the metaphor). Further, I noted lack of body language such as poor eye contact, flat voice when talking about challenges with getting the physician to make a medication change for a patient.

I also audio recorded the workshop so I could move from my field notes to the recording to check my notes against language used, tone of voice, and word emphasis. I used an abductive approach whereby I went back and forth between the literature and my notes. Orngreen and Levinsen (2017) note that the strength of the workshop is that is has a sprinkling of observation method in that the researcher can see the participants in action and the interview method in that the researcher is able to access the participants thoughts and emotions regarding their action. Further, the workshop offered the opportunity for the nurses to collaborate with me and co-construct both the meaning and knowledge surround NPNL in the PMH.

ETHICS

As indicated above, the change sought after through AR typically involves some form of re-education or changing patterns of thinking, and action, from those that are presently well established (Coghlan & Casey, 2001). In my previous role, as a healthcare educator, I had experience in curriculum design and instruction. My education, and experience in curriculum design, would have supported me to create a PMH nursing leadership curriculum without engaging in AR. However, I held deep concerns that I did not fully understand the nurses' experiences, how the nurses perceived their experiences, nor how/if the nurses perceived there was any room for enactment of leadership within their respective experiences. Further, I felt that

if I moved forward with curriculum design, without engaging in AR with the nurses I was likely to create yet another leadership course that would be a repackaging of an outsiders view of leadership and would probably be ineffective in impacting PMH transformation in a meaningful way.

However, effectively engaging in critical AR requires respecting that the participants must have the desire to change and must develop the change strategies themselves (Hinchey, 2008). I invited the nurse participants to engage in a democratic experience of defining the problem, cogenerating the knowledge, learning, and executing social research techniques, taking action, and interpreting the results of the actions based on what we could learn together (Greenwood & Levin, 2007). It was important to reinforce informed consent in relation to the research at each appropriate step (e.g., signing the consent form, participating in the interviews, participating in the focus group, collecting the vignettes, and participating in the workshop).

There are ethical risks of deceiving the participants and engaging in power imbalances during data collection (Creswell, 2013). These risks have been addressed through transparent discussion of the purpose of the study and how the data will be used. I reinforced with participants that the study would likely lead to some transformation of themselves and the PMH in which they each respectively worked. Further, I reinforced that my data collection and analysis would maintain anonymity and was focused on understanding the process of enactment of NPNL in the PMH rather than specifically understanding the individual nuances of each nurse within her specific LAP experience. I tried to impede any sense of judgement by withholding

my personal impressions and remaining focused on a questioning interview style. However, I balanced this withholding approach, with facilitating exposure of multiple perspectives and critical reflection when contrary evidence presented (Creswell, 2013). Engagement where multiple perspectives presented helped me to avoid the ethical risk of siding with the participants during data analysis (Creswell, 2013).

Further, I utilized adult learning principles which show we learn best when we can create connections between the conceptual and practical forms of expertise and knowledge (Cunliffe & Scaratti, 2017). It was important to reinforce to participants the ongoing need for self-reflection when implementing any new leadership learnings within their respective PMH. Honest discussion with participants reinforced the potential that they may struggle to transfer their learning into their leadership opportunities within the PMH. Lave and Wenger (1991) stated that where skill instruction occurs outside of performance, the skill, although performed expertly in the learning environment, may not be transferred, at least in its intended form, to the place of action. Another ethical consideration revolved around the nurses' ability to make sense of and scaffold their learning based on what they currently know, as well as building the foundation for what they will know in the future (Lave & Wenger, 1991). It was important throughout my research to go back to the concept of lifelong learning and reinforce that our knowledge is defined by our interpretation within our actionable context (i.e., we cannot fully know within our isolated self) (Lave & Wenger, 1991). Finally, it was anticipated that participation in this research could result in some changes within the participating PMHs which could potentially have dramatic impact (Glourberman & Zimmerman, 2002). It was important to share this possibility with the participants. Two participants left the PCN between the first cycle and the

second cycle of the research. For one of these participants their termination may have been precipitated by participation in the research. However, related to human resource and labour law restrictions my speculation of this situation could not be shared with the participants. This situation brought to the forefront the importance, throughout my research that I operate as a reflective practitioner and ensure that I transparently ask difficult questions regarding the ethics of my research (Easterby-Smith, et al., 2012).

QUALITY OF RESEARCH

My research clearly outlines my objectives both through, and for action, to collectively improve our experience as health system participants (Bradbury et al., 2019). I created the first cycle of research based on my informal observations within the PCN LoP and my initial literature review. Further cycles were influenced by the participants. The credibility of my research findings is based on the usefulness, or relevance, of the research as determined by the participants and myself (Greenwood & Levin, 2007). Feedback from the participants during each cycle included comments that the participants were learning a lot, thinking of things differently, proud of themselves, found the research useful in helping them articulate their thinking. Rigour is established through striving for confidence, or credibility, in the data. This has been accomplished through ensuring I have enough data over an appropriate time frame (Hinchey, 2008). Another method I used to increase rigour in the data is gathering of different types of data relevant to the same question (Hinchey, 2008). My use of different methods is in alignment with an integrative form of research whereby I was not purely affirming evidence but rather gathering greater breadth on my topic of interest (Cyr, 2019). The breadth of information I gathered through individual interview analysis, group discussion during the focus group, vignette

gathering, and finally my collaborative workshop helped me to gain a more complete understanding of NPNL in the PMH (Cyr, 2019). My thesis demonstrates an effective linking of academia from various genres to explain, challenge, and scaffold knowledge creation specific to nursing leadership within the PMH. Finally, my thesis shows the potent use of ongoing AR cycles to effect leadership-in-practice in the messy environment of primary care.

CONCLUSION

In Chapter 3 I have outlined the philosophical perspectives underlying the methodological choices I have made to explore how non-positional nursing leadership is enacted by registered nurses within PMHs in Palliser PCN. I have explored the philosophical concepts as they relate to the ontological and epistemological choices I have made in my thesis. I then justified my choice of action research (AR) and most specifically a critical interpretivist mode of AR. I provided a brief description of my AR research cycles to provide a foundation for understanding my research. I reviewed ethical considerations of my research and concluded with some of the aspects to judge the quality of my research. Chapter 4 provides greater detail on the data analysis. Chapter 5 provides an in-depth look at my intervention analysis, and finally chapter 6 provides my concluding thoughts including my concluding comments regarding the quality of my research, next steps for my organization, for my research, and for me as a both a researcher and a practitioner.

4 DATA ANALYSIS

In Chapter 1, I established the need to explore how nurses perceive leadership, and enact leadership, in the Patient's Medical Home. Further to this, I established the need to consider the impact of role identity on nursing leadership in the PMH, the impact of physician-nurse power differentials on nursing leadership in the PMH, the impact of unrecognized leadership potential on nursing leadership in the PMH, and finally the impact of lack of agreement, among nurses, about nursing leadership in the PMH. In Chapter 2, I considered relevant literature. Through my literature review I demonstrated that the vast body of leadership literature does not readily map onto nursing leadership in the PMH. I explored CoP and LoP literature as a framework to view NPNL as an iterative, context specific concept.

Then in Chapter 3 I described the underpinning of my research in the ontological position of nominalism and the epistemological position of constructivism. These choices are based on my values of free will, choice, and the ability of the individual to impact change in systems. I action my values through using critical action research as my methodology. Taking a critical approach to my action research enables the participants to better understand their unique situations, and how they are shaped and re-shaped, through discourse and context. Further, critical AR, through participant collaboration, supports the participants to transform the situations the participants find themselves in. Chapter 4 describes my data analysis process. I wrap up my analysis in the form of a visual metaphor (NPNL Flower) and describe the next steps in my nursing leadership critical action research.

As AR takes place in the present tense, it is important to explicitly reflect upon my emerging understanding and the consequent choices I make in relation to what is happening and what I should do next (Coghlan & Brannick, 2014). It is not surprising that a wide, and diverse, range of related issues arose during my research (Coghlan, 2001). As identified by Coghlan (2001), throughout my research I have had to make choices regarding what I believe to be achievable within my time and available resources.

Analysis of the data was an iterative process during which I engaged in an abductive approach. This approach allowed me to form a creative assessment of my data, link my data to the literature, form hypothesis about the data leading to sub-questions and so forth until I was satisfied that I had come to a point of data saturation and moved substantively closer to answering my research questions (Esterby-Smith, et al., 2012; Sintonen, 2004). After transcribing the interviews, I read the interviews several times such that the participants' voices could be heard during the readings. Subsequently 40 first order concepts emerged from the text as outlined below (see Appendix 3 for examples). The concepts are based on the narratives of the participants as expressed during the semi-structured interviews. Several of the concepts flow directly from the quotes or language of the participants, while others are based on the sentiment of what the participant was expressing. At this stage, I remained acutely aware of the risk of just hearing and accepting the participant's view (Gioia et al., 2012). I noticed this when I experienced a sense of hopelessness around the power and dialogue issues expressed by the participants. Most participants were positive and expressed an interest in my research to improve their leadership experience. However, the contrary comments of one participant, during my initial interviews, contributed to my sense of hopelessness.

I honestly don't think you can teach leadership. You can teach information, and you can teach protocols, and you can teach appropriate measures, but you can't teach personality traits and leadership is a true personality trait. (P007)

My own reflection and reflexivity allowed me to dig deeper into the data interrogation. Through asking multiple layers of why questions and asking myself about my own bias I was able to make greater sense of the data (Hinchey, 2008). Hinchey (2008) indicates that some broad categories for interrogating the data may include questions around time, issues, roles, behaviors, relationships, strategies, emotions, meanings, and settings. Through greater breadth, and depth, in my data questioning I was able to explicitly define my categories and subcategories. Moving my data analysis from a superficial, and implicit treatment, to a deep, and explicit, treatment assisted me to ensure clarity in the data analysis (Hinchey, 2008). Further, my abductive approach allowed me to grow from the hopeless feelings I had at the beginning of my data analysis to a greater sense of confidence, and hope, in the power of my own, and the participants,' curiosity, knowledge development, and leadership momentum.

My next step was to collate, combine and analyse my codes for second order themes. At this stage I found it helpful to refocus on the purpose of my thesis. My objective is to explore how non-positional nursing leadership is enacted by registered nurses within PMHs in Palliser PCN. The central question is, how do nurses perceive leadership and enact leadership in the PMH? The research aims to explore (a) the impact of role identity on nursing leadership in the PMH; (b) the impact of physician – nurse power differentials on nursing leadership in the PMH; (c) the impact of unrecognized leadership potential on nursing leadership in the PMH; and (d) the impact of lack of agreement regarding roles and outcomes on nursing leadership in the PMH.

RESULTS

Development of the 2nd order themes was an abductive process which allowed me to explore the messy complexity of the nurses' descriptions of how they enact NPNL in the PMH. This abductive process included analyzing my data with my existing literature review. Where my literature review was not adequate to help me theorize the results I was seeing, I sought out further research. Consequent to this abductive approach the theme of social influence was identified. Further, the key issues of knowledgeability was understood to be a component of the much broader concept of competence. The second order themes were drawn from the first order concepts and then checked against the corresponding quotes to ensure the themes reflected the respective data (Xu & Zammit, 2020). The second order themes were refined by moving between the data and the literature as I further abstracted and interpreted the meaning of the data (Gioia et al., 2012). It was important to consider implicit and explicit assumptions made, casual relationships identified, and predictive judgements regarding speed of resolution (Coghlan & Casey, 2001). As expected, I have redefined the categories, specifically the second order themes, as my knowledge and perspectives have changed throughout the analysis process. Contributing to the iteration of the 2nd order themes I moved back and forth between the raw data, the 1st order concepts and the existing literature. It has been important for me to remember that identified issue(s) are fluid, dynamic and emergent (Chiffi, et al., 2020). I continued this process until I could identify no new themes and the identified themes consistently reflected the raw data and first order concepts. Remembering that the purpose of higher-level analysis is to inform theorizing and subsequent intervention served as a motivator for perseverance in my research journey (Gioia et al., 2012).

The aggregate dimensions of NPNL interacting as practice in the PMH include identity, social influence, power, competence, and dialogue. My analysis will consider the first order concepts (see Appendix 3 for examples) resulting in the second order themes as outlined in the data structure below. After this I will consider how the resulting aggregate dimensions interact to develop NPNL in the PMH.

Data Structure

1st Order Concepts	2nd Order Themes	Aggregate Dimensions
Embarrassment when describing nursing as a physician centered activity	Value in nursing identity	Identity
Showing self and other value in nursing practice		
Leadership is part of PMH nursing	Leadership as part of nursing identity	
Leadership is extra to real nursing		
Coming to terms with the business of the PMH	Cognitive Dissonance	
What shapes the nurses identity		
Impact of no primary care nursing experience		
Nursing leadership is only done by experienced nurses	Identity changes over time	
Role changes over time		
Iterative transformation and change	Transformation and change	Competence
Pride in PMH transformation		
Leadership is taking initiative	Leadership starts with initiative	
Leadership is patient advocacy		
Confidence as seen by self and others	Confidence in self	
Rationale for change		
Lack of conviction in opinion		
Time increases confidence due to experience and education	Developing experience	
Time increases leadership experience		
Leadership is an innate characteristic or skill		
Change is slow		

1st Order Concepts	2nd Order Themes	Aggregate Dimensions
Leadership is guiding the Behavior of others	Social influence through action	Social Influence
Leadership is behaviour		
Collaborating on decisions	Developing relationships	
Feeling like you are part of the team		
Leadership is collective		
Time increases relationship effectiveness		
Nursing power and change	Positive impact of nursing power	Power
Nursing support is important to change		
Physicians have power	Negative impact of physician power	
Hierarchical roles in acute care	Hierarchy (physician at top) leads to disempowerment	
Leadership is hierarchical		
PMH is hierarchical		
Gender as a factor in relationships		
Finding the right language to initiate change	Dialogue as transformation	Dialogue
Using tentative language		
Timing of conversations		
Impact of communication skills on PMH leaders	Dialogue as power	
Fear to ask questions and make changes		
Watershed moments		
Having the nursing voice heard		

Table 3 – Data Structure

IDENTITY

Identity is a foundational aspect of becoming and being a professional (Maginnis, 2018). It includes both how a professional presents themselves and how a professional perceives themselves (Happell, 2014). Professional identity frames a professionals' way of being as well as helps the professional distinguish his/herself from other professionals (Maginnis, 2018).

In my interviews many nurses were challenged to answer questions about their PMH nursing identity. It was not unexpected that the nurses were able to articulate more easily an institutional, or acute care role as this is where the majority of their curriculum and practical experience is focused during their educational preparation.

> *I think it would be very different because when you say I'm an emerg(ency) registered nurse or I work in emerg people get very much know you work in emerg its life or death. Versus when I say I'm a primary care nurse I feel like (1) a lot of people don't even know what primary care is and (2) it is a very broad subject. I didn't even know what it was until I started working in and how much breadth and depth there is to this nursing. So if I had to tell you what that role … I don't even know … it's hard.* (P005)

As Maginnis (2018) points out a nursing professional identity develops both through using the title 'nurse' and through sharing common experiences. The sharing of common experiences is further understood through social identity theory. Social identity is determined by identifying characteristics which an individual shares with others within a given group when contrasted with a different group. PMH nurses see very little of themselves in their basic nursing (acute care) identity, and consequently, do not enter their PMH jobs with an existing professional identity. Further, development of the PMH nursing identity is hampered through limited professional references. Subsequently, we often see the PMH nurses align themselves either with a family physician identity or the family physicians' perception of a PMH nurse identity. Unclear identity formation may result in a weak valuing of the PMH nurse identity.

> *I might not be able to perform up to that standard that she (the physician) thought. Really proving myself. We have had that discussion too about my role versus her role and what the expectations is. Because at first coming into it, I didn't know, you know it was such a vague guideline that I didn't know where I stood.* (P008)

Further, another participant talked about the struggle to prove her value to the physician while still ensuring she worked within the scope of her practice.

> *I think it helped having an RN in the office where my physician now kind of knew the scope of practice and it wasn't so much me always saying like I'm really sorry that is not within my scope I cannot do that and then kind of creating that sense of well what can you do and always having to re-explain or kind of prove I'm of value. I learned a lot from the first physician and my own nursing practice and just how to kind of have that*

> *relationship and prove that I'm needed too and that I add value to your patient and your clinic. (P005)*

Not only are these nurses struggling to identify the knowledge, skills, norms, and values which comprise PMH nursing identity, they seem to be challenged with developing a sense of belonging. Reid et al. (2008) state that a sense of belonging to a profession includes acquiring a body of knowledge, a sense of history of the profession, as well as the practices and skills that are part of the profession. As PMH nursing is a relatively neophyte specialty, with little to no attention during academic training, it is not surprising that the nurses have difficulty articulating their practice and determining how leadership fits into their practice. This tension is further highlighted by the pressure some nurses feel in balancing the needs of their patient with the need to keep the physician they work with content.

> *It's about meeting the physicians' needs and making their day easier and I think we get caught up in that instead of it being about your patients. (P003)*

The nurses were torn when determining if leadership is part of every nurses' practice or is an extra skill learned by some nurses at a certain point in their respective careers. When the nurses related leadership to overall patient wellbeing, then they became more confident in aligning nursing leadership as part of day-do-day nursing identity.

> *Nursing leadership, even though we are the leaders in the clinic I feel like even though it didn't sound like that I feel like the nurse does drive every aspect just because I suppose we are more involved with the patient and we look at them as a whole so we see all parts whereas the physicians don't necessarily look at every single area so the nurses are the leaders where it comes to the patients and their Health Home. (P003)*

This finding was in keeping with work done by Gordon et al. (2015) who found that medical students were more likely to identify leadership emergence when they could relate it to informal

direct patient care events. Further, in a literature search focused on clinical leadership and nurses, Stanley et al. (2018) were challenged to find a conclusive definition of a clinical leaders or leadership. This literature search showed a breadth of definitions which vacillated with inclusion of many concepts including position, influence of others, experience, expertise, and advocacy (Stanley et al., 2018). With this level of confusion in the nursing leadership research it is not surprising that nurses themselves struggle to identify leadership within their respective practice. One participant referred to learning about leadership while in training and referenced this experience as a 'fad'.

> *There was half the year in nursing, in school like it was a fad that came up for a while and we were all like oh ya, leadership in nursing and I got that instructors advice. And she was like as students, you guys do this. We were trying to be leaders. (P002)*

This comment is disturbing as it indicates that nursing leadership is only of interest and purpose for a brief period. This finding is in alignment with Clark (2008) who found that nurses struggle to consider themselves as demonstrating leadership as they are more inclined to associate leadership with a positional leader. This comment may also indicate a bigger problem with the academic CoP in that the nursing school CoP may not be integrating leadership in a manner that mirrors the PMH professional environment many of the nurses enter (Reid et al., 2008). This issue has been brought forth by other researchers noting that professional identity is developed through exposure to academic ideals and then clinical realities (Hunter & Cook, 2018). Where new nurses are exposed to experienced nurses who act as positive role models, appropriate professional behavior is enabled and reinforced (Hunter & Cook, 2018). This phenomenon was made evident by a participant who worked in a clinic with several other PMH nurses:

> *I feel like with acute care I see leadership as being a stressful thing and not an easy thing and aggravation whereas this seems to be a natural part of the progression of the*

> *development of the primary care network to me. That we have all just kinda grown into that. The 'we' being the nurses in the clinic. That we have all grown into that and developed it in a way I suppose as a group. But I think all of the nurses that I know that are doing the same job definitely have a leadership role in their clinics. Absolutely.* (P001)

This practice of watching others is referred to as learning the 'hidden curriculum' of the organization and is recognized as a mechanism through which nurses manage the gap between theory and practice (Allan et al., 2011). Further, nursing literature stresses the importance of role models in the construction of nursing identity (Walker et al., 2014). However, most of the Palliser PCN PMH nurses work in a clinic environment without other nurses and subsequently may struggle to identify a role model and find solutions to the theory-practice gap. Hunter and Cook (2018) state that when the nurse recognizes the gap between academic ideals and practice realities, she experiences a sense of discomfort known as cognitive dissonance. This phenomenon can be motivating to the nurse or may lead her down a road of powerlessness and increasing distress (de Vries & Timmins, 2016). Those nurses who are motivated to resolve their cognitive dissonance are likely to turn to the physician they work with to understand the 'hidden curriculum' the in the PMH.

> *I don't know if it's coming from acute care where you always have tasks and you have to tick this box and that box. Primary care is so broad. You know I had all this knowledge about all these different chronic diseases but I wasn't sure how to harness it and where to focus. You know there wasn't really any feedback at first. So it was kind of waiting. So I finally went to my physician and said am I doing what you expect me to do? There is nobody looking over your shoulder and so you have to be independent and take leadership. So after we had that conversation about what else can I do and how else can you use me better and what can this look like. Then I had a clearer guideline. (P008)*

Further, this type of role modeling from the physician helps the nurse increase her experience of belonging, acceptance, and inclusiveness which in turn has significant impact on how nurses enact leadership within the PMH.

> *Working in a clinic has been a very different environment and like working in emerg those leaders that I have always had the perception of has been your doctors. Your doctors are, everything that you do is gone through them, ordered through them, put through them, whereas now working in a clinic I feel I have a little bit more autonomy and I'm a little bit more respected in my own role and things that I can do. (P005)*

On the surface the intertwining and identity development of nurses by physicians seems counterintuitive to an autonomous profession. However, as identified by Johannessen (2018), in his work on nursing-medical boundary blurring, when a competent nurse can engage in boundary blurring work the quality of the nurses' work is likely to increase. Wikstrom and Dellve (2009) support the value of boundary-spanning and shared responsibility to engage in effective leadership-as-practice in process orientated environments like the PMH. This concept is further supported by Frost (2010) who found that strategic interaction among colleagues helps to embed the type of change required in a transformational environment such as the PMH. The strength in this type of concurrent leadership (Raelin, 2003) comes from capitalizing on who is most knowledgeable in each situation.

From the analysis above it is possible to claim the nursing identity new graduate nurses, and nurses who have only worked in acute care, come into primary care with is insufficient to effectively navigate NPNL in the PMH. In efforts to decrease his or her cognitive dissonance, the nurse is likely to turn to his or her physician colleague to help shape his or her PMH identity. As the nurse begins to develop his or her PMH nursing identity, along with boundary blurring work, he or she may begin to engage in leadership activities within the PMH. This transformative process is well articulated by Villanueva (2020) who looked at the professional identity formation of physicians in Mexico. Villanueva (2020) noted that identity incorporates four elements: mental state (feeling and thinking like a doctor), expression (behaving like a

doctor), recognition, and response (being seen and treated as a doctor). Similarly, I have found that the PMH nurse identity is based on the nurses' experience (feeling and behaving like a PMH nurse – initiating collaboration and advocacy), mental state (having the confidence of a PMH nurse), and finally recognition and response (being seen and treated as a PMH nurse – influencing clinical and non-clinical change from a respected position within the clinic).

COMPETENCE

In 1959, White defined competence as an organism's capacity to interact effectively with its environment. White (1959) went on to say that in simple organisms this capacity would be innate, and boundary limited. However, in humans with their large frontal cortex, and plastic nervous systems, competence is uniquely, and situationally, developed over prolonged learning (White, 1959). In more recent literature, researchers have attempted to distinguish the concepts of competency and competence; competency is defined as a list of critical behaviors, skills, knowledge, and attributes, while competence is a framework outlining the process and work results required to achieve goals (Teodorescu, 2006). These current definitions of competence seem to have taken on a positivistic view of leadership and are unsuitable for addressing the messy problem of non-positional nursing leadership in the Patient's Medical Home. A more suitable framework can be found in cognitive science which looks at the development of cognitive processes, and the knowledge underlying these processes, over the course of time for expertise to develop (Lord & Hall, 2005). Lord and Hall (2005) go on to note that within the area of leadership this meta-cognitive development addresses both progress towards goals as well as the social factors which shape the context in which the leadership occurs. Building on

the concepts presented by Lord and Hall (2005) I will be considering competence as a malleable attribute developing from the interaction of change and transformation, initiative, and confidence, over time.

The transformational change within the PMH requires changes to clinical practice, organizational practice, as well as how physicians, nurses, clinic staff and patients think about primary care (Potworowski & Green, 2016). Reflective of the PMH literature, the nurses I interviewed had varied language to describe the changes required to move family physician clinics towards the PMH model. The interviewee below refers to change as 'evolving.'

> *The clinic is constantly evolving based on all our input including the patients'. Maybe not as much as it could, but that is definitely part of it. Collectively it is not a super-fast process, we don't have a set of steps we follow but it definitely occurs over time; and that is everyone. (P001)*

This quote encapsulates several aspects of transformational change including the intentional changing of cultures, practices, and assumptions over time (Greenwood & Hinings, 1993; Kezar & Eckel, 2002). Additionally, reflective of the complexity within each PMH, the above quote shows the nurses' recognition that even with concrete clinical items there are not specific steps to be followed to ensure transformation. This lack of a detailed road map, combined with a lack of precise experience in primary care, left all the nurses lacking confidence in their ability to engage in NPNL within the PMH.

> *So as a nurse in this environment I'm just self-leading myself basically. I've always had people above me saying this is what we are going to do, this is a new policy, this is a new whatever. I'm enjoying the freedom to be a nurse, be a real nurse, to make my own decisions and know when to order labs and stuff. But I'm kind of leery about doing too much.* (P006)

A lack of self-confidence has been closely tied to a reliance on others to solve leadership issues and provide direction (Kipnis & Lane, 1962). Unfortunately, this broad assessment has reinforced trait-based leadership models whereby only those with innate confidence are suitable for leadership positions. However, in recent years the concept of self-confidence within leadership has been more clearly unpacked from other concepts such as self-esteem and further extracted from a simplified trait-based assessment (Hollenbeck & Hall, 2004). Hollenbeck and Hall (2004) identified self-confidence as being a judgement based on our perceptions of our capabilities and what the task requires. Consequently, leadership self-confidence is task specific. It was clear in my interviews that when a nurse had related experience and/or knowledge her confidence was greater. The below interviewee demonstrates this as she describes the types of situations where she must act; namely where a patient safety issue may exist.

> *If it does come down to a quality of care, safety of care for sure encourage, help facilitate, motivate, inspire, all those words for that nurse to go to the physician. (P003).*

Patient safety is a familiar area for all nurses, including new graduates. From both an academic, and experiential perspective, nurses are exposed to patient safety and their professional responsibility in relation to enhancing patient safety. It is therefore not surprising that the nurses are able to build on their patient safety experience and express leadership in this area. Where the nurses have the confidence to engage in leadership, they engage in a circular positive experience which facilitates greater confidence in initiating changes.

> *Whereas when you work in Home Care if you want to try and change something well you are sending a note to the physician and you are trying to get in contact with them. Whereas when patients come into the office and the patient is there, we are having that real time discussion. So, I think it is really powerful. We can get together and we can problem solve right then and there to make those changes. (P008).*

This finding is supported by Hollenbeck and Hall (2004) who showed that as leaders can engage in self-reinforcing positive cycles their confidence in influencing change grows. This concept of time (experience) naturally leading to self-confidence was reflected by some of the interviewees.

> *I am a novice nurse. I should sit back and listen. I have a lot to learn. What I know could be summarized on a little note. All this gathered experience has a lot more to teach me than I could possibly teach them.* (P002)

The passage of time is only impactful for self-confidence when it leads to self-reinforcing positive cycles. This requires the nurse to take the initiative to engage in change experiences and adopt a cognitive outlook whereby each experience is an opportunity to learn (Billet, 2008; Frese & Fay, 2001). Personal initiative is behavior that is recognized as stemming from the individual, being proactive, and persistent in overcoming difficulties (Frese & Fay, 2001). Frese and Fay (2001) go on to say that self-starting indicates that the individual does something without being told, without explicit instruction and/or without it being an explicit role requirement. Further, Frese and Fay (2001) claim that for a self-starting action to be considered personal initiative it must have a comprehensive perspective that embraces the group and/or the organization.

> *I care about my patients and I want to be there and that I'm bringing new ideas back. Not just sitting there twiddling my thumbs and waiting for something to fall into my lap I'm very proactive that way.* (P008)

This concept of personal initiative in PMH transformation is in alignment with Frost (2010) and Raelin (2003) who indicate that team members must gather and use evidence in a collaborative manner to engage in effective problem solving and change. Raelin (2003) focuses on the cognitive aspects of collaboration through his description of the dispositions found in effective collaborators including a genuine sense of curiosity regarding the opinion/action of others, a desire to submit one's own ideas and views to the critical inquiry of others, and a view that this

mutual inquiry may result in something new or unique. Further, collaboration is closely tied to the concept of critical thinking which requires the ability, or disposition, to be open-minded, pay attention to the situation at hand, seek reasons and try to be well-informed (Ennis, 1985).

> *Its more in primary care that critical thinking component is huge. And I definitely wasn't prepared for that. It came over time and education.* (P003)

Clearly, collaborative thinking is a starting point for the personal initiative required to engage in PMH transformation; however, moving from collaborative thoughts to having the initiative to act requires self-confidence. Since self-confidence results from perceived capability minus perceived task requirements, it is amiable to factors outside of direct and exact experience (Hollenbeck & Hall, 2004). Namely, modeling, or watching others perform both successfully and unsuccessfully, social influence, and management of emotional arousal have been shown to have significant impact on self-confidence (Hollenbeck & Hall, 2004). NPNL modeling is only available where the nurse works in a clinic with other nurses. This is by far a minority of PMHs in the Palliser PCN.

Regardless of whether the nurse could observe modeling or not in their place of work, the observation only becomes useful when the nurse engages in critical reflection, reflexivity and in turn action. As early as 1985, Ennis described critical thinking as as the outcome of reflection and application of reasonableness to determine what to believe or do. More recently Billet (2008) identified active engagement in workplace learning as a requirement for workers to transform their workplace practices. Learning is being used in the broadest sense of formal, informal, explicit, and implicit such as modeling. Billet (2008) clearly links the thinking and action part of the competence equation stating that lifelong workplace learning is a relational

concept whereby workers subjectively engage with their changing workplaces via their individual personal agency (confidence) and intentionality (initiative).

NPNL competence is a malleable attribute developing from the interaction of change and transformation, initiative, and confidence, over time. A key aspect of competence is that it occurs in, and as, practice and therefore cannot be explicitly taught. Further, competence will change over time based on intrapersonal and interpersonal factors. Competence has both cognitive and behavioral components that work in a mutually influencing manner. In other words, if the nurse believes herself to be effective at enacting NPNL she is more inclined to behaviourally engage in NPNL. In a self-fulfilling manner if a nurse engages in NPNL behaviour she is more likely to believe herself to be effective in engaging in NPNL. As such, NPNL is also developed through social influence and is a driver of social influence.

SOCIAL INFLUENCE:

Where individuals have opposing views, conflict may develop. Sammut and Bauer (2011) differentiate conflict resolution between hard power, or coercion tactics, and soft power, or social influence tactics. Social influence is the soft power communication tool used to achieve consensus thereby resolving a conflict (Sammut & Bauer, 2011). In other words, the intended outcome is for the communication recipient to align their thinking, and behaviour, with the individual exercising social influence (Sammut & Bauer, 2011). Hendel et al. (2019) state that social influence is expressed via sharing knowledge, and experience, through relationships with others in the workplace. In alignment with the social influence literature, the nurses in my study

articulated value in supporting their opinions with research when trying to convince the physician towards a course of action.

> *If I read this this amazing research article and we should think about tweaking this process or something than I would make sure she has that article. Or, like coming back from an education day I would always make sure she has the notes and then if there was something from there that I want to suggest then she knows the information that I do.* (P001)

This reliance on evidence is interesting as several researchers have noted that, although nurses articulate the value of evidence-based practice, everyday nursing is more likely to be based on the nurses' personal experience rather than on research evidence (Squires et al., 2011; Yoder et al., 2014). This problem is so extensive that several studies have explored the factors impacting nurses' limited use of evidence-based practice in day-to-day work (Brown et al., 2010; Bostrom et al., 2013; Mashiach, 2011). In their empirical study of explanatory factors for the use of evidence in nursing, Skela-Savic et al. (2017) found that values of caring, trust and justice, and everyday practice competencies, did little to influence the use of evidence-based practice. Rather, in alignment with social influence, the values of activism, professionalism, and competencies focused on the professionalization of nursing, are more likely to increase evidence-based practice in nursing (Skela-Savic et al., 2017). The nurses expressed these values in a self-fulfilling manner such that the use of evidence empowers the nurses to engage in social influence, and further leadership, which in-turn empowers the nurses to use more evidence.

> *Over time, experience, education, evidence' you just learn that you are able to question. It is evidence based, I have the ability or the knowledge to question and work together with my physicians. (P003)*

Kaplan (1987) specified this type of social influence as informational influence whereby consensus is sought by building on the other parties' desire to make the best decision possible.

Frost (2010) described the drive to contribute to the creation and dissemination of professional knowledge as a leadership action. At times, this leadership action is negatively impacted by impaired self-confidence. In alignment with the findings of Hollenbeck and Hall (2004) the nurses found that the emotional arousal they felt when experiencing a conflict negatively impacted their purposeful use of social influence as a leadership dimension.

> *I let (the physician) guide the conversation so to not ruffle feathers. I feel my confidence is a big piece of that and I don't like conflict. (P010)*

In alignment to the findings of Fattore et al. (2009), the nurses found that their relationship with the physician provides a social influence mechanism to shape behaviour and influence performance. Henningsen and Henningsen (2015) describe this type of social influence, focused on the unique relationship between two individuals, as idiosyncratic influence.

> *I think because we have a good relationship now, I've been there for over two years, I can come back and say this is what I learned at my workshop, these are the new forms, you know we are going to replace these, this is what it looks like, and its accepted.* (P008)

For some research participants, engagement in social influence was less impacted by evidence and more impacted by workplace relationships. The concept of social influence is closely tied to personal initiative, and in turn innovation, as it is through purposeful engagement in workplace relationships that individuals change their work routines, overcome barriers to new work processes, and gain new knowledge and skills, and positively influence workplace transformation (Hendel et al., 2019).

> *I think leadership has to do with not only empowering people to work alongside you, with you, towards common goals, not just empower them but to motivate them. So I think a large part of leadership is motivating your cohort or staff or peers to want to do their best.* (P006)

Social influence is one of the expressed dimensions of NPNL in the PMH. Social influence is used to drive the behaviour of others and engage in collective leadership activity (Raelin, 2003). The nurses tend to rely on evidence to support their social influence with the physicians. This is not surprising as, often, conflicting views in the PMH are related to opposing clinical and/or operational opinions based on differing evidence being used by the physician and nurse. As supported by the findings of Skela-Savic et al. (2017), the more professionalized the nurse becomes, the more he or she is likely to increase evidence use into his or her practice. Further to this, the greater the use of evidence, the more likely the nurse is to engage in informational social influence. Influence and power are sometimes used interchangeably; however, the concepts are not the same. As indicated above, influence is the action to create change whereas power refers to the potential means available to an individual for changing the attitudes and behaviour of another (Schwarzwald, et al., 2006; Raven, 2008). This distinction is important as we dig deeper into the nurses' perceptions of power and its role in nursing leadership within the PMH.

POWER:

Touching on power as one aspect of NPNL is challenging due to two competing factors. One being that power remains a challenging concept with many competing theories (Bradbury-Jones, et al., 2008) while at the same time recognizing that focusing on only one paradigm can blind the researcher to competing lines of inquiry (Braynion, 2004). My thesis does not allow for a full exploration of power. However, given the historical foundation of power relations between physicians and nurses I will briefly touch upon hierarchical power and I will then move to a

poststructuralism perspective on power to explore the perspectives of the nurses engaging in PMH transformation in my research.

Hierarchical power is an exercise of positional power over another to control or dominate (Manojlovich, 2007). A hierarchical power differential between physicians and nurses is well documented, and alive and well in acute care, where nurses receive the majority of their training and typically start their careers. Typical nurse-physician acute care interactions are based on the over 100-year-old Nightingale ideals whereby the nurse is considered, and considers herself, a simple instrument through whom the doctor gets his instructions carried out (Pritchard, 2017). The impact of this archaic model of nursing was articulated by some participants.

> *You have that fear in nursing school. Doctors are intimidating and talking to them was intimidating. I felt working on a nursing unit that the physician was intimidating.* (P010)

The reality of the modern nurses' training, responsibility, and accountability does not match the perceptions of the typical physician in terms of what they believe nurses are trained to do, responsible to do, and accountable to do, as an autonomous profession (Pritchard, 2017). That said, nurses still struggle with personal identity when comparing themselves to physicians while at the same time craving recognition and appreciation based on the physicians' senior position (Lotan, 2019).

> *The physicians' expectations are what has dictated what my capabilities are in that office.* (P001)

This type of domination is described as power over (Laverack, 2005). As early as 1967, Dr. Leonard Stein outlined what he called the nurse-physician game. In summary, nurses were observed as bold, having initiative, and being responsible for important recommendations and

advice while appearing passive (Radcliffe, 2000). Further to this, the nurses use subtle techniques to make ideas appear to be initiated by the doctors in efforts to not undermine the physician authority and avoid inter-professional conflict (Radcliff, 2000; Fagin & Garelick, 2004).

> *I feel I give a lot of power to the physician. And I think it is kind of an undertone and I have heard nurses in the network say if your physician is happy you are happy. Just make sure you are following what your physicians want to do. It's about meeting their (the physicians) needs and making their day easier and I think we get caught up in that instead of it being about your patients.* (P002)

Some nurses clearly voiced participation, and acceptance, of the nurse-physician game.

> *You don't want to be confrontational, you want to … not tip toe around it but it's kinda, maybe I'm wrong but if I am what is your rationale? Teach me.*

However, other nurses found the PMH environment tended to be more respectful than what they had experienced in previous hospital environments and subsequently they tended to be clearer and more direct in their dialogue with physicians.

> *So it was just a whole different experience for me to sit down and I guess maybe there had always been, I felt like a bit more of a hierarchy working on the floors whereas working sitting next to my physician I felt really respected and they wanted my opinion and it was actually really gratifying to say hey this is what I think is going on and have some insight and have that validated. I think it boosts your confidence as well.* (P008)

Not surprisingly gender arose as a complicating factor in the power relationships between physicians and nurses. However, the traditional sexual stereotypes of nurturance and passivity in women, and decisiveness and competitiveness in men, (Thompson, et al., 2011) were less clear and pronounced in the PMH.

> *Working in a hospital I definitely did see gender differences. Working with male physicians was a lot more intimidating. Where it was I'm strong and I'm macho and I know everything versus sometimes working with females who are a little more soft hearted and compassionate*

> *versus the male cohort. So I have definitely noticed that but now from the clinic. Having worked in 2 clinics I can't say I have really noticed anything in terms of gender in the clinic.* (P005)

Consideration of gender by the research participants was inconclusive with seemingly balanced perceptions on the positive and negative influences of the gender of the nurse and/or the physician. This finding is in keeping with the findings of Shen and Joseph (2020) who performed a review of gender and leadership research. Shen and Joseph (2020) found that although there is substantive, and growing, literature regarding gender and leadership there remains significant gaps in this area of research. Although this complex area of research demonstrates differences in behaviours, it is less clear where, and when, particular behaviours are more or less effective (Shen & Joseph, 2020). Further, it is unclear what impact gender bias has when leadership is viewed as a complex, integrative process (Shen & Joseph, 2020). Given the complex, integrative environment of the PMH it is not surprising that gender findings were not clear.

The PMH nursing workforce will need to keep gender stereotypes in mind as they address power issues when enacting leadership. However, the meaning of, and impact of, any gender stereotypes is yet to be discover in practice. Looking at power through a hierarchical and gender-based lens is in keeping with critical social theory (Bradbury-Jones, et al., 2007). Critical social theory looks at enabling the disenfranchised members to overcome domination (Applebaum et al., 1999). However, as discussed earlier, power is not always repressive and so I must broaden my approach. I initially considered a social psychological approach to address this problem whereby nurses are empowered to engage in personal growth and development to change their own perceptions of the power relationships and influence (Bradbury-Jones, et al.,

2007). However, this approach relies solely on the nurses' internal work and may naively overlook the cultural and political influences on power (Bradbury-Jones, et al., 2007).

Alternatively, a postructuralism approach, based on the work of Foucault (1980), considers power as being in a dynamic state, as well as having both positive and negative characteristics (Bradbury-Jones, et al., 2007). The poststructuralism approach helps to frame the shifting tides of what is considered truth in healthcare knowledge and further how this relates to the structures of power within which nurses and physicians co-participate (Braynion, 2004). Gabel (2012), in his description of the physicians' role in healthcare transformation, recognized the utility in learning, and further leveraging, skills to communicate information or expertise effectively to take full advantage of informational power. However, using a poststructural lens I posit that the PMH nurses in my research have equal (perhaps greater) access to informational power regarding PMH transformation. For the nurses to influence these power structures they must strive to understand, and further leverage, the strategic elements of power such as dialogue (Braynion, 2004). One mechanism by which the PMH nurse may harness this power into NPNL is through demonstration of his or her critical thinking and knowledge via dialogue skills. Clark (2008), in her work on clinical leadership, recognized this and encouraged the nurse to understand that communication as an action of the nurse is fully within the nurses' control and modification. In other words, the nurse is not to be victimized by how others receive her communication but rather should focus on modifying her communication if misunderstood or not achieving the results she wishes (Clark, 2008). A post-structural lens framed my understanding of how dialogue presented in my interviews both as power and a transformation tool.

DIALOGUE

Dialogue is a broad concept applied to both represent practice (that which has occurred) and to influence practice (that which is, or will, occur) (Alvesson & Karreman, 2000; Cunliffe, 2016; Lave & Wenger, 1991; Raelin, 2012). Dialogue is essential to help us articulate the mental models guiding our NPNL action, to examine our mental models, and to influence NPNL emergence within the PMH (Downey, et al., 2011; Raelin, 2012). Dialogue surfaced throughout my research on a continuum from simple conversation to the leadership practice of gaining deeper understanding, expanding perception, and developing new ways of communicating (Stains, 2012). I will explore the surfacing of dialogue within my data and then demonstrate the key role of dialogue-as-practice in NPNL emergence in the PMH.

While dialogue is shaping knowledge and action it is also shaped by the social environment in which it is occurring, the historical experience of the speaker and the time at which it is occurring (Bjornsdottir, 2001). As such the identity the nurse brings to the discourse has significant impact on how the dialogue will occur. Identity is closely intertwined with dialogue as identity shapes professional understanding, motivation and commitment through ongoing dialogues, while at the same time influencing those ongoing dialogues (Stenberg et al., 2014).

> *That I'm a novice nurse is my biggest obstacle. I get scared or intimidated every time I do these little things. Like things that can be changed in the clinic and presenting them to the physician. It comes with a lot of anxiety. How is this going to go? How are they going to receive it? Is it going to work? Is it right? I think the fear is the obstacle. Fear of failure. That it is going to go horribly wrong. That the physicians are going to say that is a terrible idea that it is not going to work. Or that we try it and it is more work or leaves something a mess, lets a patient down.* (P002)

In turn dialogue, both external and internal, influences the development of identity (Assen et al., 2018). This relationship is conceptualized through the Dialogical Self Theory (DST) which sees self as a dynamic multiplicity of I's. I's are identities which although held internally are expressed externally through dialogue (Meijers & Hermans, 2018). Of particular interest in DST is the development of professional identity which is conceptualized as occurring at the boundaries of various I-positions which frequently causes discomfort (Meijers & Wardekker, 2002). Assen et al. (2018) found this discomfort may result in feeling victimized, entitled, imagining needing rescue or blaming. This concept has been reinforced by several researchers who have viewed nurses as an oppressed group who weakly avoid conflict and are powerless (Attree, 2007; Roberts et al., 2009; Atwal & Caldwell, 2006). This type of research results in a self-fulfilling prophecy (Merton, 1948) whereby the nurse creates a professional identity which is weak and powerless and further dialogues in a weak and powerless manner reinforcing this identity. The theory of the self-fulfilling prophecy has been recognized by research in different contexts. Stenberg et al. (2014) in their work with developing teachers, found that the developing professional identities had significant influence on how the teachers shape, control and select information towards their ongoing learning. In turn the particular information and learning the teacher engages in shapes his/her developing professional identity (Stenberg et al., 2014). As such, dialogue is both an outcome and an input into the various identities of the nurse within the PMH.

> *You are part of their (patients) Health Home. I think there is a big ah ha moment where I'm needing to collaborate with others, work with others, go to the physician, question things, just advocate for that patient. Right off the bat I think that is one thing that pushes that novice nurse to become more of that leader.* (P001)

As established earlier, teams are a foundational component of PMH transformation. Further to this, nurses must engage in these teams to help identify and solve patient problems, contribute to treatment plans, and perform interventions (Propp et al., 2020). Where nurses can call on a variety of strategies to meet the varying needs of a specific dialogue, they are better prepared to meet the dynamic environment of the PMH (Apker, et al., 2005). Further to this, the nurses in my research were able to harness communication skills such as using a tentative style of speaking to express interpersonal sensitivity and further increase the likelihood of obtaining the physicians' consent and involvement in the dialogue (Leaper & Robnett, 2011).

> *You know "I was thinking this might be a good idea what do you think about it", and sometimes it is a flat out no right away and sometimes the flat out no goes away and thinks about it for a while and comes back with a counter offer.* (P001)

Previous commentary regarding nurses' reticence to speak up has been blamed on a lack of assertiveness on the part of the nurse (Garon, 2012). However, this is not always the case, as identified by Timmins and McCabe (2005); nurses sometimes choose not to speak up as they have determined speaking up would impair their interpersonal relations, cause conflict, and may not help them achieve their dialogue goal.

> *You have to work with different personalities and you have to have an end goal of what you want done and realize that whether everybody thinks it was you that got them there or not doesn't matter because you got what you wanted. You got done what you needed to get done.* (P009)

Apker, et al. (2005) support this less victimized look at physician-nurse relations through the lens of dialectics. In brief, dialectics gives us a framework to understand the fundamentally contradictory nature of relationships, the subsequent tensions that arise, and the communication behaviours that influence, and are influenced by, context (Baxter & Montgomery, 1996). Of interest to my research is the equal-subordinate role dialectic whereby there is tension between

the new role of nurses as assertive, collaborative, equal power decision making partners with physicians, and the traditional role of nurses as subordinates to the expertise and education of physicians (Apker, et al., 2005). Apker, et al. (2005) found that nurses employed indirect forms of communication with physicians in a manner that they have input into the decision making without the physician being aware such that the nurse maintains his or her role as a subordinate. This was an evident skill used by several nurses in my research.

> *Offer a little bit of you know 'would this work' or 'I have a suggestion do you want to hear it' and just really sort of navigating it with caution* (P004)

Dialogue helps the nurse understand and articulate the power dynamics in the PMH and further when considered as-practice dialogue becomes a strategic power tool.

One of the dialogue roles the nurse faces in the PMH is to support decisions through ensuring there is sufficient quality information being used to make decisions (Propp et al., 2010). This role is impacted by the dialectic of autonomy-connection (Baxter & Montgomery, 1996) whereby the nurse feels tension between being an independent, objective professional and engaging in concern for developing the relationship between the team members (Apker, et al., 2005).

> *I think that that is a trepidatious time because I think you have to go about it in a way where you can demonstrate your knowledge and your critical thinking and your judgement without coming across like the know it all, or you know better or something like that.* (P005)

These tensions are described by Meijers and Lengelle (2012) as occurring at the boundaries of what the individual understands as self, environment, and relation to others. This tension can result in I-positions which are in opposition and contribute to self-conflict and self-criticism

dialogues in the individuals' personal narrative (Hermans & Hermans-Konopka, 2010; Meijers & Lengelle, 2012). However, as identified by Sammut and Bauer (2011) where this tension is critically identified and articulated to self, dialogue may be applied to exercise social influence and positively influence and/or resolve opposing views or conflict across time and place (Meijers & Hermans, 2018).

Finally, dialogue surfaced as the mechanism through which the nurses expressed competence. The nurses expressed competence as capacity to effectively interact with the environment (White, 1959) as well as development of knowledge underlying goal directed processes (Lord & Hall, 2005; Teodorescu, 2006).

> *We need to keep moving forward and evolving. Everything around us is going to change, if we don't change too then what happens. One thing that I didn't consider at the very beginning is that change is possible in the environment itself. I felt like I had to fit into a set environment. I learned I can shape that environment and contribute to that environment.* (P001)

Critical reflection and reflexivity are required to understand that choice of perception and language (both forms of dialogue) are in the individuals' hands; he/she comes to understand that he/she holds a position of power within the dialogue (Bjornsdottir, 2001). Critical reflection and reflexivity provide insight into an individuals' internal narrative so that it can be reframed to initiate change rather than accepted as a negative interaction to be eliminated and/or avoided (Baxter & West, 2003). Further dialogue, as expressed through critical reflection and reflexivity, propel the PMH nurses from a place of acceptance, victimization and/or confusion to a place of opportunity for development, adventure, and implementation of many contextually specific forms of NPNL (Apker, et al., 2005; Borrott et al., 2016; Martin et al., 2008). This positivity is

applicable to others as well as self. Framing dialogue as an opportunity to value the contributions and dignity of others, even when in opposition to ones' own ideas, aligns with Raelins' (2003) conceptualization of being compassionate (Martin et al., 2008). Critical reflection and reflexivity occur through purposeful dialogical interactions between self and others as one works towards understanding and organizing experiences (Hermans & Hermans-Konopka, 2010). These purposeful dialogical interactions, critical reflection, and reflexivity, require dedicated structure and guidance for fulsome growth and development (Stenberg et al., 2014).

In the next section, I reflect on the relationship between these five aggregate dimensions and the essential role of critical reflection and reflexivity in drawing together my analysis of the findings.

ANALYTIC REFLECTION

In chapter 4 I have analysed my interview data using the Gioia et al. (2012) method, and using an abductive approach. This method enabled me to take the breadth of responses I gathered through my initial interviews and organize them in such a manner that I was able to inform both my theorizing regarding NPNL in the PMH, as well as my proposed intervention. As expected, from my literature review, current leadership models are inadequate for the PMH as they look at isolated aspects of leadership in insulated environments and do not consider the complexity of nurses working in family physician clinics transforming to PMHs. Nor do any existing leadership models sufficiently address how the nurse may engage in leadership without being assigned a leadership role and further how the nurse must navigate the significant complexities

within the PMH. My research has shown that in some instances, and to varying degrees, non-positional nursing leadership is emerging in various PMHs.

Below I have updated my PMH Leadership Emergence Conceptual Model to reflect my research findings. My research confirmed the existence of a nursing CoP within the PMH. I did not confirm nor discredit a physician CoP, a clinic CoP, or any other CoP. It remains probable that these CoP exist and as such I have kept these concepts in my model. The CoP are represented by quadrangles, rather than pyramids, simply to allow space for the addition of social influence and power to the interacting concepts forming the CoP. I confirmed that these CoP are in a constant state of internal change depending on the interaction and influence of identity, competence, social influence, power, and dialogue. Further, I confirmed that each CoP, within a unique PMH, is a permeable construct allowing the CoP members to move in and out of the CoP as they are able based on their knowledgeability. The arrows going to and from the CoP quadrangles to the center oval of reflection and reflexivity are impacted by, and impact, dialogue. The middle oval is the space where knowledgeability, and in-turn leadership emerges. Over time this leadership emergence develops into the structure of a specific PMH CoP. As members of a PMH CoP begin to enact non-positional leadership they do it more and do it more effectively. Finally, the bottom oval in my model shows the overlap of various PMH CoPs across the LoP of the entire primary care network as the actors within the PMHs are provided opportunity to engage in collaborative reflection and reflexivity.

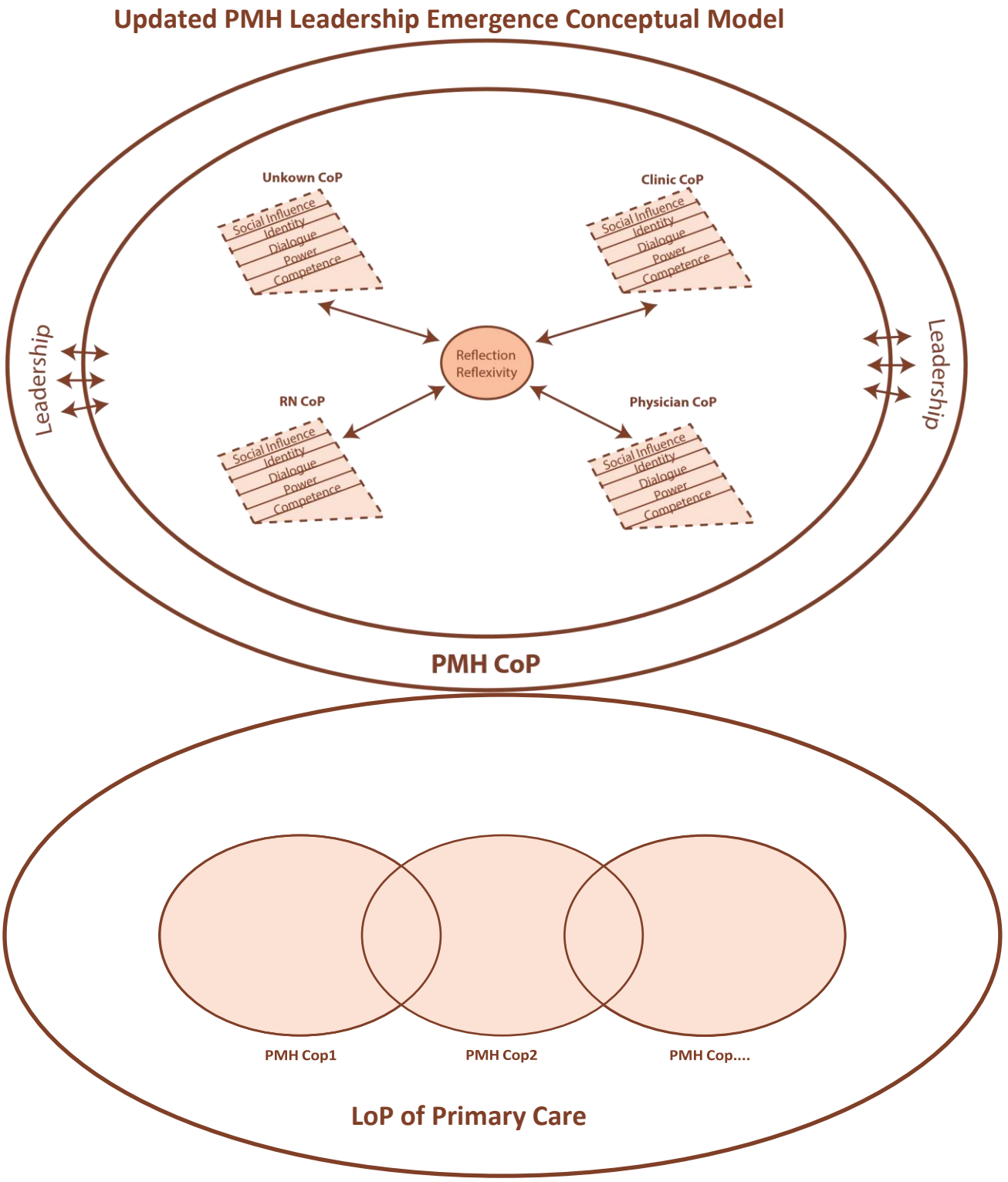


Figure 4- Updated PMH Leadership Conceptual Model

I decided to create a visual metaphor to summarize my findings as this helped me to demonstrate both what the nurses have achieved, as well as what they are pursing in support of PMH transformation (Carton, 2018). One aspect of my research involved helping the nurses make sense of their current leadership experiences. Further, my research helped the nurses consider how they might make sense of, and influence, their future leadership experiences. These efforts involve conceptualizing a new mental model of who they are as PCN nurses (Gioia & Chittipeddi, 1991; Hill & Levenhagen, 1995). I have chosen a group of visual metaphors to represent my findings as visual metaphors help to convey complex insights and also assist in creating a shared understanding (Hill & Levenhagen, 1995; Schwartz, 2020). Further, as identified by Bird (1992), my visual metaphors help to indicate both intended direction (propagation) and unintended consequence (wilting). My flower of NPNL demonstrates the overlapping, and yet distinct, white petals of identity, power, competence and social influence. These petals are supported by the sepals of first order NPNL concepts (individual experiences) depending on the reproductive capabilities of the pistil (center) of dialogue. The petals grow from the center of dialogue. The entire flower head is grown on a stem of critical reflection and reflexivity which is watered and fed by lifelong learning.

Figure 5 – NPNL Flower (5 dimensions)

It is important to note that the dimensions identified in my research do not have the same weight for all nurses. In fact, dimension weighting (influence) is likely to vary from situation to situation and from time to time. For example, my research recognizes that, despite the calls for egalitarian teams, many primary care teams are still based on a hierarchical archetype, with physicians in a power position and retaining decision making authority (Propp et al., 2010). Given this environmental contextual component, nurses in these situations must determine how to impact this power differential to best meet patient needs, positively impact PMH transformation, and feel empowered in their NPNL role (Garon, 2012). For some nurses they

may experience less hindrance from the above power differential and have a greater focus on social influence. This may be evident where the clinic the nurse is working in is more actively engaging in PMH transformation. Frese and Fay (2001) support this concept noting that as the rate of innovation and transformation increases, personal initiative becomes more important. Personal initiative supports the nurses to think of creative ideas and implement the creative ideas into practice. This research result is in keeping with my literature review whereby leadership-as-practice is occurring such that the PCN nurses are able to enact NPNL as they best determine on a situation-by-situation basis (Raelin, 2016b).

Existing leadership literature separates the 5 NPNL dimensions into distinct entities. Although potentially more achievable from a didactic position, focus on one dimension, as a unique item, is unlikely to develop the required knowledgeability (Pyrko, et al., 2019) to positively impact NPNL. PMH practice is highly complex and subsequently requires a comprehensive approach. Improving enactment of NPNL in the PMH will require looking at the intra- and inter-relationships of the dimensions and the resultant dynamic sphere of influence at a particular nurses' disposal. Each of the dimensions is porous and intertwined and consequently an intervention which attempts to address a single dimension without the other dimensions, or attempts to address a dimension without considering the unique micro and/or macro environment, will be unsuccessful. That said, a framework differentiating the dimensions while still showing their interconnectivity is necessary to facilitate sensemaking (Weick, 2020) of NPNL. This is represented in the diagram with four petals of power, identity, social influence and competence surrounding the pistil of dialogue. Dialogue is represented as the pistil of the flower as it is central and required to develop the petals. An unhealthy pistil cannot support

robust petals. The diagram clearly shows that the flower head (the pistil and petals) are supported on a firm stem of reflection and reflexivity. The stronger the stem the more healthy, and likely to propagate, the flower of NPNL becomes. Stem development occurs through the nourishment of lifelong learning, which is represented in my diagram through the watering can.

While, many scholars present transformational change as a journey, I challenge this metaphor. A journey has an identifiable beginning, end, way points, and a route map. However, I see NPNL as an ongoing, context-based, emerging process that can be nurtured. Further, in the instance of NPNL, the journey metaphor does not fully recognize the dimensions of NPNL and the role of dialogue as practice. Every nurse has a unique potential of NPNL. The rate at which the PMH transformation occurs, and the NPNL is enacted, is impacted, and influenced, by the internal and external environment in which both are occurring. The internal environment is reflected in the nurses' knowledge, and experience, with the 5 dimensions as well as reflection and reflexivity. The external environment includes the landscape in which the NPNL flower is trying to grow (a given PMH at a given point in time) as well as the water of lifelong learning. Lifelong learning carries the nutrients required to germinate critical reflection and reflexivity to ensure growth, transformation, and propagation. NPNL flowers which are not watered with lifelong learning will become fragile and eventually die.

Figure 6 – NPNL Flower - Wilting

NEXT STEPS

The nutrients of knowledgeability will flow from individual and organizational endorsement of a culture of continuous learning and development, rather than application of known best practices. Further, knowledgeability is developed through ongoing relationship development, renegotiation, and reconfiguration of boundaries, as well as identity and meaning across the PMH LoP (Omidvar & Kislov, 2014).

Fertilization of NPNL in my research participants will start with a 2-hour virtual focus group to present my findings and my model of the NPNL flower. Following the focus group, the nurses will be asked to track 2-3 occasions over the following 2 weeks and submit these occasions to me to develop vignettes for a 3-hour workshop applying collaborative reflection and reflexivity to help the nurses with sensemaking regarding their professional thinking and skills (Hetzner, Heid, & Gruber, 2012) around NPNL. Collaborative reflection is a mechanism to reveal assumptions and further impact PMH transformation (Greenwood & Hinings, 1993; Kezar & Eckel, 2002), and has been associated with improvement in identity, competence, social influence as well as power and dialogue (Bartunek, 2010; Hetzner, Heid, & Gruber, 2012). In other words, a healthy, yet basic, petal development of the NPNL flower.

CONCLUSION

In Chapter 4 I have described my data analysis process. My data analysis clearly showed the complexity of nursing leadership in family physician clinics transforming to PMHs. Further, my data analysis demonstrated the inadequacy of current leadership models to address this complexity. I conclude Chapter 4 with the introduction of my visual metaphor of NPNL and describe the role of collaborative reflection, reflexivity and lifelong learning in healthy growth and development of NPNL. Chapter 5 provides an in-depth look at my intervention analysis and the possibility of a more robust flower of NPNL. Finally, chapter 6 provides my concluding thoughts including my concluding comments regarding the quality of my research, next steps for my organization, for my research, and for me as a both a researcher and a practitioner.

5 INTERVENTION ANALYSIS

Chapter 4 provided my analysis of my interview data via application of the Gioia et al. (2012) method using an abductive approach. My initial interviews, and literature review, have provided a mechanism to explore how NPNL is enacted by registered nurses within Palliser PCN PMHs. I was able to uncover, and analyse, how nurses perceive leadership, and enact leadership, in the PMH. Further, the data analysis brought insight into the complex interaction of identity, competence, social influence, power, and dialogue on NPNL in the PMH.

This chapter describes the next steps in my action research which included a suite of reflective and reflexive interventions including a focus group with the participants, followed by the nurses completing a homework assignment of postcard vignettes, and finally a workshop focused on a specific practice based NPNL topic. Through this intervention of critical reflection and reflexivity activities I was able to support the emergence and/or accelerate the enactment of NPNL as it exists in the individual nurses' context. As identified by Cunliffe (2002a) reflection is a simplifying process with the aim to identify patterns and logic and reflexivity is a complexifying process with the aim to identify contradictions, doubts, and possibilities. Reflection and reflexivity were intertwined both in the leadership research and on the leadership research. At the beginning, and end, of each research cycle I briefly reviewed where I was, and where I was going in the next steps of my research. At these points I invited the research participants to provide their guidance regarding how I was analyzing the results, any concerns they had, and what I was planning for the next stage of my research. This collaboration ensured the nurses were giving consent in an ongoing, and informed manner and helped drive the research towards outcomes that were meaningful to the nurse participants.

This suite of interventions is based upon the assumptions that (1) collaborative reflection will assist the nurses to move from a position of blame and victimization to a place of control and influence (Cleary et al., 2018; Raelin, 2016a), (2) collaborative reflection will assist the nurses to recognize their collective NPNL identity (Cleary et al., 2018), and (3) collaborative reflexivity will assist the nurses to develop personal accountability for themselves, their actions, and their relationships with others (Cunliffe, 2009). Further, the dialogue skills learned, practiced, and refined in collaborative reflection and reflexivity are expected to enable the nurses to develop new ways of talking and acting (Cunliffe, 2002a) as they observe themselves through their interactions with the other nurses (Cunliffe, 2002a; Raelin, 2012). Finally, in alignment with action research methodology (Thorpe & Holt, 2008) I expect that through hearing and seeing the nurses articulate and reframe their NPNL struggles and successes I will be guided to design improved learning activities and working supports in this sphere of primary care nursing.

FOCUS GROUP

A 2-hour, virtual, synchronous, focus group was chosen to facilitate the research participants to both engage with me, and each other, regarding my preliminary research findings in a respectful and friendly environment (Stewart, et al., 2007). A focus group is an appropriate research device for a small group of relatively homogenous participants to engage in dialogue around a specific topic (Thorpe & Holt, 2008). Liamputtong (2011) supports the use of focus groups to understand the meanings and interpretations the nurses ascribe to NPNL in the PMH. The focus group provided me an opportunity to present a brief overview of my leadership literature review, my data analysis from the initial interviews, and finally my preliminary research findings in the

form of my visual metaphor of the NPNL flower. The focus group provided further qualitative data including the reactions, opinions and thoughts of my research participants to advance my thinking around NPNL. Liamputtong (2011) supports the use of focus groups to help interpret qualitative data, and further confirm researcher findings. The open dialogue and narrative scaffolding among the participants helped to both express robust opinions of the nurses, and also, solidified the validity of my findings and my metaphor. Stewart, et al. (2007) support this research process stating that group discussion often results in rich ideas that would not be possible through individual interviews or more quantitative methods. Finally, the participants engaged in socially moderated dialogue such that they organically challenged, and weeded out, extreme views (Hennink, 2014). This resulted in a collective narrative regarding the participant perspectives of NPNL (Hennink, 2014).

Although the participants were likely to have some knowledge, and perhaps even know each other, the focus group was the first time they were able to identify who was in the research project outside of themselves. We did a round of introductions, reviewed confidentiality, reviewed the potential harm that could be experienced by participants (e.g., breakdown in physician-nurse relationship if they are seen as sharing information outside the PMH) and I reminded the research participants of the consent process each of them engaged in at the beginning of the research. I chose to use an outline of the focus group as my discussion guide relying on my trained ability to ask probing and clarifying question while at the same time reinforcing that the participants would be able to take the conversation in whichever direction made sense to them as a group (Hennink, 2014). The focus group outline included a brief overview of various leadership paradigms, a presentation of my interview research findings

(Table 3: Data Structure), and presentation of my NPNL flower. The questions which underpinned the focus group included:

- How does leadership fit into PMH transformation?
- What type/form of leadership is required to support PMH transformation?
- What is the nurses' role in PMH leadership?
- How did you/are you learn(ing) about your nursing leadership role?

At the beginning of the focus group the nurses made some comments regarding how difficult it must have been for me to make any sense of their interviews, particularly because they came to the interviews without any preparation of what the interviews would be about. There was a sense from the nurses that they should have known that what they do on a day-to-day basis could be described as leadership and furthermore they were deficient in some manner for not being able to clearly identify this:

> *"It is surprising, and embarrassing, that as a profession we have difficulty expressing our leadership"* (P003).

I provided the nurses with a brief overview of various leadership paradigms as outlined in my literature review. In efforts to make the theories more accessible to the nurses I was sure to provide examples which would be familiar to the participants. For example, with LMX theory I used the example of nurse unit managers grooming their successor such that the style of leadership may not change for decades in a given hospital environment. Further, in describing the heroic leadership model I described the PMH literature focus on physicians as the obvious, natural, only leader of the PMH. The nurses stated this was not surprising to them as they see

the physicians struggle to provide leadership even in areas where they have less expertise than the nurse. The nurses spoke positively about their response in filling these leadership gaps.

> *"the physicians in our homes are focused on looking after patients and getting out at the end of the day; it is us, the PCN nurses who drive the breadth of the PMH, like improvement, I find the physicians appreciate this"* (P007).
>
> *"I am able to tell the physician what I can do and I find he is not only receptive but excited about how I can make the clinic and patient care better"* (P008).

Another leadership example I provided was trait-based leadership. I linked this back to the style of leadership the participants have found to be successful over their careers and the lack of homogeny among those styles. This point was well made with the following opposing statements:

> *"I think a good leader has to be clear in telling you what to do."* (P001).
>
> *"A good leader is effective at asking you questions so you come to your own decisions*" (P007).

When I presented information around Leadership-As-Practice the participants became very animated and began providing their insights into how they felt this theory was much more reflective of their experience even though they would not, prior to engaging in my research study, have identified their thoughts, behaviours, or activity as leadership.

> *"At the first interview I didn't think the things I was doing every day were leadership. But once I went through the interview process I realized that little things that I do on a day-to-day basis are not just part of our jobs they are actually leadership!!"* (P008)
>
> *"I am surprised to think about the things I do every day, particularly with patients, as perhaps being part of leadership"* (P002).

At this point in the focus group the nurses were clearly taking ownership of the conversation as evidenced by their posture (e.g., leaning towards their camera and making eye contact), their dialogue characteristics (e.g., more energetic and animated) and their dialogue content (e.g., use

of words such as responsible, pride, and action). I presented the individual interview data structure (Table 3) to the nurses. The nurses stated they could see themselves in the data and started to engage with the data unprompted making statements such as "neat", "cool to see", and "I can't believe you were able to pull this into a coherent thought". The nurses even began producing their own theories about what was driving the data and furthermore began challenging each other's ideas such that they were able to begin developing a counter story to the master narratives regarding nurse leadership behaviour (Lindemann, 2001). The counter story began emerging as the nurses voiced their shared perceptions of nurse enactment of leadership within the PMHs.

> *"I think we get mixed up about leadership versus power and decision making"* (P009).
>
> *"Within the health home the physician values us and so clearly that provides a greater sense of nurse power than in the large acute care team where the physician may not see or recognize what the nurse does on a day-to-day basis"* (P008).
>
> *"Within the PCN we are given so much autonomy that we are able to make recommendations and take leadership in areas that are within our scope" (P008).*
>
> *"At the base of nurses struggling with identifying their leadership is that they are often not the final yes or no but that said the nurse is making suggestions and using dialogue to lead care and lead practice change"* (P007).

At this point in the focus group, I presented my visual metaphor of the NPNL flower. The nurses voiced a quick understanding, affinity and pride in the metaphor as evidenced by the following statements:

> *"It's awesome. I like it because it has a sense of positivity to it"* (001).
>
> *"It's easy to understand and explain to others. Like if you weren't from a nursing background I think you could still understand this. This will not only help nurses but it will help others to understand us and that what we do is important"* (005).
>
> *"I think this will definitely help us as nurses. It gives us a framework to grow our leadership from"* (008).

> *"Especially in primary care there is nothing. This is cool, it helps me to see that although one of my petals might not be as big as others it is just as good as someone else's leadership flower because it is growing in my specific context"* (010).

Metaphors have been found to both increase understanding of abstract and ambiguous concepts as well as influence attitudes, feelings, and behaviours regarding the target concept; in this case NPNL (Bultmann, et al., 2020). The nurses discussed the NPNL flower at length discussing not only how it reflected their current states of NPNL but also how they could grow NPNL in the unique PMH circumstances and further how unattended NPNL would die. In their research with language learners, Bokhorst-Heng and Marshal (2020) found that metaphors help us to interpret our experience and beliefs and consequently develop the metacognitive skills required to explore our identity. As such metaphors may be used to transform ourselves and our future practice (Bokhorst-Heng & Marshal, 2020). The focus group was generative with the nurses building on others' ideas as expressed through dialogue. In reflecting on the NPNL flower the participants voiced recognition that dialogue is at the center of all they do both because of their individual context and as a malleable source of creating and influencing their context. The focus group concluded with the nurses using words such as "excited" and "looking forward". The next phase of the intervention involved the nurses capturing NPNL vignettes, based on in-situ experiences in their respective PMHs, over a 2-week period.

VIGNETTES

Vignettes may be used as a method of qualitative research whereby the vignettes are written by the participants in a guided manner to elicit the participants' beliefs, emotions, judgements, attitudes, and values about a particular phenomenon (Skilling & Stylianides, 2020). Within my research I planned on using vignettes as realistic case studies for the purpose of ongoing NPNL

enactment intervention (Bradbury-Jones, et al., 2014). A vignette format was chosen as it would not have been practical, or perhaps ethical, for me to observe the participants within their respective PMHs (Paddam, et al., 2010).

Each participant was provided with 3 NPNL postcards reflecting the NPNL flower in a growth state, a propagation state, and a dying state. Although the graphic on the postcard did not need to correspond with the vignette, I did want to remind the nurses of the metaphor and the concepts we discussed such as nurturance through lifelong learning, building strength through improved reflection and reflexivity, and finally wilting through neglect. The nurses were asked to capture 3 situations or events, positive or negative, which they felt reflected one aspect of the NPNL in their situation. The nurses were encouraged to include as much detail as they could, including their personal thoughts, beliefs, and emotions with the only restriction being that it had to fit on to the postcard provided.

Prior to assignment of the vignette homework the nurses were informed of the vignette development process I would be using which included grouping the collected vignettes into like sections of the NPNL flower metaphor (dialogue, identity, power, social influence, and competence). Further, I would combine the vignettes within a single category into a composite vignette to assist in protecting the anonymity, confidentiality, and safety of the participants (Bradbury-Jones, et al., 2014). Having the participants provide the mini-vignettes as part of the vignette construction was in alignment with my action research approach and assisted in making the vignette as contextually relevant as possible while still not requiring the participants to retell

or relive what could be a potentially emotional, vulnerable, or upsetting experience (Bradbury-Jones, et al., 2014).

Given the workshop time allowance I prepared 2 composite vignettes. I chose the 2 composites based on volume of participant vignette submissions as well as submissions that were fulsome in their description and/or appear to be exemplars of NPNL in PMH. Volume was included in my decision making as a proxy of participant interest. The composite vignettes were respectively focused on identity and power. Ultimately only identity was covered in the NPNL workshop, so the identity composite is included below:

> *When I first walked into my clinic to work I felt like an outsider. Nothing in my education or experience had prepared me for the autonomy, responsibility and isolation I felt as a PCN nurse. On top of this the patients ask who I am, what my role is and what I am going to do for them. The patients want reassurance that the physician is not dumping them, that the physician knows what is going on, and that I know what I am doing. When I have trouble with a patient I go to the doctor and he/she tells me what to do. However, sometimes the physicians' clinical knowledge is out of date. It is challenging with patient education as the doctor comes in and tells the patient the same thing I told them; it doesn't usually work. I know the patient needs a different approach but the physician thinks the patient will listen because the advice is coming from the physician. It is even more challenging with practice improvement/panel work as the physician drivers/focus and the patient drivers/focus do not usually match.*

This vignette provided insight into the nurses' internal narratives and formed the framework for the next phase of my action research which is described in the next section.

NPNL WORKSHOP

A workshop format was chosen as the next step in my suite of interventions to impact NPNL in the PMH. I chose the workshop format to engage the participants in use of the NPNL model.

The workshop format was an appropriate choice as it offered participants the opportunity to try out new ways of thinking and dialoguing about leadership in a safe environment. Further, through collaborative dialogue, participants would be able to move from identification of challenges in enactment of NPNL towards a more positive, solution focused framing of NPNL. My NPNL workshop was organized via video platform (GoogleMeet) in a 3-hour timeslot. The workshop started with a reminder regarding confidentiality and consent to be a research participant. Following this I did a brief overview of my action research cycles to date. The review included:

- an overview of the individual interviews exploring the nurses' perceptions of their leadership within their respective PMHs;
- an overview of the focus group which looked at presenting, and validating, the findings from the individual interviews; and
- a debrief of the experience of gathering real life vignettes with the goal of creating a series of master vignettes in alignment with the flower of NPNL visual metaphor.

The high level objective of the first NPNL workshop was to utilize a master vignette to examine the nurses' perceptions, beliefs and attitudes, as expressed through dialogue, towards enacting and/or accelerating enactment of NPNL in the PMHs.

The brevity of the vignette was an important consideration related to the challenge of holding participants attention during a virtual workshop (Bradbury-Jones, et al., 2014). The vignettes allowed me to acknowledge the individual nurses' experiences and the meanings they subscribe to PMH situated nurse leadership (Michael, et al., 2016). As identified by Hughes (1998) vignettes allow participants a less threatening opportunity of responding from a third person perspective. Finally, using vignettes provided a realistic, yet safe, space whereby the nurses

could respond to the described event sharing their beliefs, perceptions, emotions, as well as promoting reflection, reflexivity and future planning among themselves (Skilling & Stylianides, 2020; Bradbury-Jones, et al., 2014).

During the workshop I was struck by the nurses' lengthy discussion regarding their responsibility to bring forward new ideas and new knowledge within the PMH. The nurses went on to identify that leadership is not a binary situation (i.e., you are either doing it or you are not doing it), rather it occurs on a continuum and is in a continuous state of evolution. After making insightful comments such as this the nurses would often comment that they perceived they had been too wordy, or maybe gotten off track with the discussion. It was important to reassure the nurses that there is no right, or wrong, answer and part of identity development is found in dialogue with others (Lindeman, 2001).

One nurse was an outlier stating that she would only be able to work through the process of NPNL identity development if the physician she works with is onboard (P001). After further dialogue with her colleagues, nurse (P001) agreed that PMH nurses have a leadership role in PMH transformation; however, this nurse remained constrained in her perception of PMH transformation identifying it as a 'program' of transformation versus day-to-day actions. Although she distinguished PMH transformation from day-to-day clinic activity, nurse P001 did reluctantly identify that she engaged in small acts of leadership every day. The other participants were more easily able to identify small components and steps towards transformation. This change in dialogue was keeping with Lindemann (2001) who describes narrative repair occurring when individuals can move from acceptance and victimization to a place where all experiences

are an opportunity for development. There was a strong theme among the nurses of an "ah ha" moment with capturing the vignettes whereby the nurses found they initially were stumped by looking for big leadership moments but then, when they stopped and considered the individual NPNL dimensions, they saw NPNL happening all the time. One nurse summed this up well:

> *"I realized that I had not been giving myself enough credit. After the focus group I began to notice I would have thoughts like dang that was leadership right there"* (P010).

The workshop offered the nurses an opportunity to engage in purposeful dialogue such that they could recognize their differences, create shared meanings, and begin to more clearly identity and articulate their nursing leadership identity (Cunliffe, 2009; Ospina & Foldy, 2010). As I explored in my literature review, identity is developed through learning within a community also known as social becoming (Murillo, 2011; Wenger, 2004).

> *"I know why I struggled with the vignettes I was looking for a big leadership event but listening to everyone else leadership isn't 1+1=2 it is a very complex formula and we are not likely to ever get to the end or get to a perfect solution"* (P001).

> *"Environment has a lot to do with my identity. In previous acute care jobs I had a list of tasks and my identity was accomplishing those tasks by the end of the day. In primary care there is a lot more critical thinking and I define myself by how well I am thinking"* (P003).

The nurses experienced an environment of safety in the workshop such that they were able to effectively engage in bi-directional dialogue as they supported the reflection and reflexivity of their colleagues within the research group.

> *"Our leadership includes recognizing our strengths such as coordinating all aspects of care and when we hit a weakness reach out for the strengths of others, say doing the biopsy on a breast lump. We don't do everything but we lead the process of things getting done* (P009). *I just want to say we should replace the word "weakness" with*

> *perhaps limit or boundary of scope. This is not a weakness; which is negative language"* (P010).

The vignette offered the nurses the opportunity to think more critically and reflexively regarding themselves and their actions (Cunliffe, 2009). Further to this the nurses organically began to engage in an empowering approach whereby they began to voice their personal ability to manage their own behavior (Druskat & Pescosolido, 2002).

> *The vignette makes me ask myself why it is uncomfortable when the patient challenges my knowledge and/or position. Why doesn't this sit well with me? This is my issue to sort out it is not the problem of the physician nor the patient. Don't throw away a whole situation because something didn't work. Pull it apart and learn from it* (P009).

This bi-directionality in dialogue opened up the space for the nurses to begin development of new linguistic norms to offer increased opportunity for NPNL to emerge (Garrett & Baquedano-Lopez, 2002).

> *"Limiting words like still, only, just, rookie, green, inexperienced. This process has helped to replace my language with more positive words"* (P009).

Further to this, the nurses spoke extensively on the value of having a visual model to reflect their experience and then the opportunity to talk about their experience in a safe, group atmosphere.

> *"The metaphor of the petal helps me identify where I am strong and where I'm a bit weaker; it is perpetual improvement"* (P005).

This insight is supported by the work of Shotter (2003) who makes the argument that it is not until an object or event is talked about that it becomes a social reality and as such individuals are enabled to act. Raelin (2012) further argues that dialogue helps us to articulate the mental models that guide our action and further allow us to examine if our models are leading us

towards constructive involvement in collective action. The shared NPNL narrative developed and articulated through workshop helped the nurses summarize both their experience and their role in impacting their iterative leadership enactment within their respective PMHs (Contu & Willmott, 2003).

> *The process prompted me to look at myself and my leadership qualities. This type of group activity helped me unpack my behaviour and supported me to accept that I'm not alone. It also gave me some dialogue and reflection/reflexivity tools to implement on a daily basis.* (P008).
>
> *This experience has renewed my commitment to be aware of my internal thought habits which may be interfering with my confidence and consequently my identity as a nurse leader* (P001).

Bakhtin (1981) argued that the best reflection is social and collaborative because it is through dialogue that meaning is created and learning deepened. Bokhorst-Heng and Marshal (2020) support this concept stating that identities evolve when students negotiate, discuss, and voice their concerns, experiences, and emotions. Effective reflection and NPNL identity emergence both occurred during my workshop.

Although I had prepared a 2nd master vignette, focused on power, there was only 25 minutes remaining in our 3-hour workshop. It had taken approximately 2 hours for the nurses to exhaust their thoughts and dialogue regarding identity, so it was clear there was not enough time to discuss power. Further to this, the energy in the group was dropping off. I felt the nurses had put extensive effort into their reflection and reflexivity and as such were showing signs of mental fatigue (e.g., slowed speech, slumped posture). I chose to end the workshop and not pursue dialogue around the 2nd vignette. This decision was disappointing in that I had planned to

explore the dimension of power in this cycle of my AR. That said, I had already concluded that it would not be possible to explore all dimension of NPNL in a single workshop. Initially, I had made this decision based on time available to conduct a single workshop. Upon reflection, it was equally, if not more important to consider the emotional and mental exhaustion which occurred in a deeply reflective and reflexive experience. I believe I was overly ambitious in thinking I could explore more than one NPNL dimension in a single workshop. It was more important to have the research participants fully engage with the dimension of identity than to push through a superficial discussion to ensure I met the originally constructed endpoint of two dimensions (identity and power). Finally, it was important to engage with the participants in an authentic manner being aware of, reflecting on, and engaging in action which recognized the experience of the participants within the workshop. I demonstrated, with the participants, being able to change course of action in a responsive manner. It is expected in AR that following an intervention, the identity workshop, a project will need to be revised and improved for the next cycle. Future iterations of my NPNL workshops will purposefully be designed to fully explore one dimension per workshop, allowing for modifications between the workshops.

DISCUSSION

As identified in chapters 1 & 2, PMH transformation is not moving along at the rate desired and expected by governments, professional associations, or individual practitioners. A factor in this slow change is a lack of effective leadership within the PMH. Medical schools, professional associations, colleges and governments have applied resources to physician leadership within the PMH with minimal return on investment. I argue that an untapped resource to accelerate PMH transformation is nursing leadership within the PMH. On first glance several structural

limitations exist in emancipating the potential of nursing leadership within the PMH, not the least of which includes the lack of nursing hierarchical position within the PMH. Such limitations are expected in action research and drive the researcher to ask more strategic questions such as what can be done at this time, within the current confines of the social environment along the journey of improvement (McNiff, 2013).

As identified in my interview analysis (chapter 4), nursing leadership-as-practice within the PMH environment is messy, iterative and often unrecognized. I value strengths-based approaches to life's messy problems and this shows in the approach I have taken to my action research. I believe in the power of the human spirit, and the ability of healthy humans to determine their own thoughts, and in turn, practice. Susan Bredlau, (2020) in coming to terms with the impact of power on our interactions with our world, encourages us to accept that we must take responsibility for, and learn how to cooperate with political and cultural institutions that we do not control. Bredlau (2020) goes on to state that our personal power comes from understanding that our power exists in the control we have regarding the meanings we assign, and subsequently the ways we interact, with these institutions.

As predicted by Argyris et al. (1985), my research challenged the status quo from the participants' collective perspective as they helped to diagnose, engage in new patterns of thinking, and new forms of reflective and reflexive collaborative dialogue. Using an action research approach had the advantage of engaging the participants by providing structure and focus on the problem of NPNL such that we could understand, and build on, the wisdom of those doing the work, and experiencing the problem, to explicitly identify opportunities for self and

other learning and improvement (Hinchy, 2008; Bredlau, 2020). My research provided the nurses an opportunity to explore their individual enactment of leadership and further to dialogue and influence their emergent leadership selves. As the nurses participated in the intervention their trust in themselves, the process, and each other developed such that they had increased energy and confidence to reinterpret the behaviour of both themselves and others.

In terms of an action research approach what was exciting to me was the robust, and focused, dialogue among the nurses as they participated in the shared process of creating knowledge and putting theory into practice. During the research experience the nurses began practicing new dialogue skills as they joined in collaborative reflection and reflexivity (Cunliffe, 2002a). The nurses were able to use what they had learned about various leadership models to reflect on what they had experienced in both previous, and current, nursing environments. This simplifying process was applied by the nurses, to themselves, as they noted the dialogue they used to describe their experiences (Cunliffe, 2002a). Further, the nurses demonstrated improved skills in critical reflexivity during the workshop as they began to identify contradictions in their dialogue and behaviour, express doubts over what they were, and were not, doing, and began to see the possibility of growing their specific NPNL flower(s) (Cunliffe, 2002a). The data showed the nurses constructively challenging each other in their choice of dialogue, and consequently meaning, while remaining respectful of the specific circumstance each nurse was experiencing.

My research supported the nurses to identify and verbalize their existing leadership activities and further to incorporate this as an integral part of who they are, and their identity as a PMH nurse. Organizing the nurses' insights into a simple, dialogue centred, flower model provided the nurses

with validity of their current experience, acknowledgement of their unique situation- based thoughts and actions, hope based in the power of collective reflection and reflexivity, and strength, based on recognizing self as an evolving being through lifelong learning. The flower metaphor was easily understood by the nurses and they quickly adopted it as an accurate reflection of both their current circumstance and their potential for future leadership growth. The flower metaphor provided the nurses with joint language to explicitly consider their leadership within their respective clinics and to collectively engage with a master vignette, during the research workshop. The flower metaphor helped the nurses both make sense of their current leadership experiences and to conceptualize a new mental model of who they are (Gioia & Chittipeddi, 1991; Hill & Levenhagen, 1995).

The collaborative reflection during the workshop facilitated the nurses to move from a position of blame and victimization to a place of control and influence such that they were able to collectively articulate their primary care nurse identity as occurring in day-to-day leadership across a breadth of areas such as patient care, clinic processes, and practice improvement (Cleary et al., 2018; Raelin, 2016a). The collaborative reflection regarding NPNL enabled the nurses to find their own feelings, thoughts, and reactions in the experiences of others thus accelerating the growth of their nursing leadership identity (Løvaas, & Vråle, 2020, p. 275). The nurses voiced parallels between their own NPNL improvement and the lifestyle improvement they coach in patients whereby a focus on changing meanings and interpretations of behaviours makes possible a change in the behviours themselves (Cunliffe, 2002a; Raelin, 2012).

This was an exciting juncture in the research as it was at this point that I saw evidence that Leaderful practice could materialize in the non-utopian, messy world of the PMH. The nurses recognized that they engage in leadership *concurrently* with physicians, patients and others in the PMH depending on who appears to have the greatest expertise in a given situation and what strategically seems to be the best course of action to achieve a particular change (Raelin, 2003; Frost, 2010). Further, the nurses recognized that leadership in the PMH is *collective* and requires all hands on deck including the receptionist, the medical office assistant, the patient, the nurse, the physician and others (Raelin, 2003). The nurses went on to describe this collective leadership as occurring at many levels including problem definition, solution search, and solution enactment. The nurses expressed an interesting transformation of thinking regarding the *collaborative* aspects of leaderful practice (Raelin, 2003). Initially, the nurses indicated that they were comfortable and regularly precipitated in collaborative dialogue. Further, the physicians were frequently demonized for not being open to this type of dialogue. However, during our focus group, vignette, and workshop development, the nurses noted several interesting aspects of collaborative dialogue including their own variability of engagement. They noted this occurred even in the safety of the research project, where they discussed their variability in expressing their beliefs and values with patients and physicians, and their lack of prompting of this type of dialogue in other team members. By the conclusion of the workshop, most of the nurses indicated that waiting for others to collaborate seemed disingenuous if they were not willing to engage in this manner themselves. A cautious commitment to improve this aspect of their NPNL was articulated.

Finally, the nurses expressed an interesting turn of thought regarding the *compassionate* aspect of leaderful practice (Raelin, 2003). Initially, the nurses expressed that compassion must come from the physicians, specifically in the form of his/her respect for the opinions of the nurses and the patients. However, as the nurses engaged in the workshop they came to deeper understanding and personal commitment to compassion that included seeing everyone, including themselves, as engaging in lifelong learning and consequently doing their personal best with what they know at a given point in time. Raelin may not agree with my interpretation of leaderful practice existing in what is, in many instances, a hierarchical environment. However, my research has shown that NPNL in the PMH is relational, reflexive and situated and as such it emerges from exploration of our dialogue and actions within the messy environments where we reside (Cunliffe, 2004; 2009).

At the beginning of the initial focus group the nurses indicated that certain petals of the NPNL flower were necessary before other petals could grow (e.g. a well-developed power petal precedes development of a competence petal). However, as the focus group, and then the workshop, occurred the nurses voiced an increased sense that not all aspects of the leadership flower can, nor should, be fertilized at one time. Further, the nurses expressed that all leadership flowers should be expected to grow in a non-uniform manner. Finally, at the end of the workshop the nurses expressed a sense of personal accountability for themselves, their actions, and their relationships with others (Cunliffe, 2009). This insight supports inclusion of Realins' (2003) 4 C's of leaderful practice (collectivity, collaboration, concurrence and compassion) as additional petals on a well-developed NPNL flower as illustrated by the addition of the dark orange petals in the diagram below.

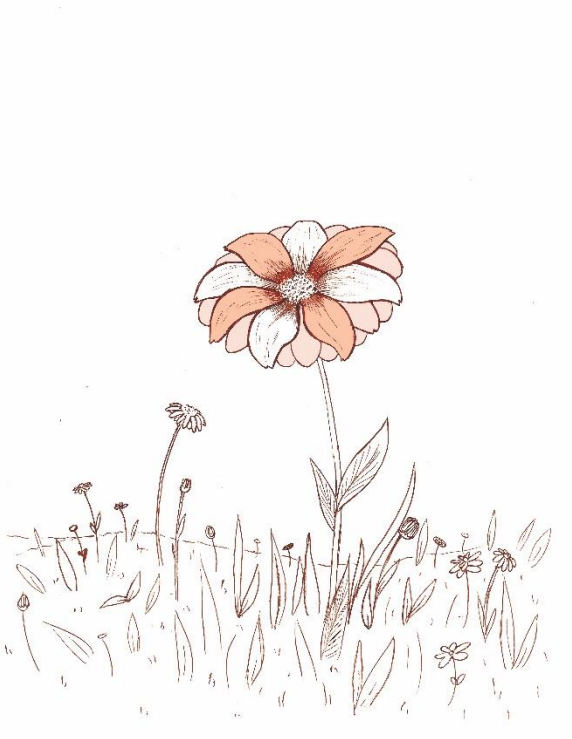


Figure 7 - NPNL Flower - 5 Dimensions + Leaderful Practice

Acquiring new knowledge and understanding in NPNL enactment will assist the PCN in moving forward with providing more effective support for nurses to enact non-positional leadership in a manner that promotes PMH transformation. From a practice perspective my research has shown that a model, developed from the nurses' experiences, helps to structure their ongoing dialogue, learning and leadership enactment. I expressed this model in the form of my NPNL flower metaphor. I was able to prove my concept of using a metaphor as an intervention through which the nurses could find space to engage with themselves, and each other, as leaders. This approach positively supports how the nurses are enacting leadership in their current practice, while also enabling the powerful stance of appreciating the inventive and nuanced leadership development in which each nurse is engaging (Scott & Armstrong, 2019). I do note that in its purest interpretation leadership-as-practice cannot be enacted outside the in-situ environment (i.e. the PMH). However, I argue that the nurses need a safe environment, such as the NPNL

workshop(s), to engage in the messy side of leadership as it emerges from exploration of their actions, dialogue, and ways of making sense; including consideration of power (Cunliffe, 2004; 2009). Each nurse is an expert on whether this level of safety exists in his/her PMH. Additionally, as identified by other researchers, collaborative reflection results in deeper reflection and consequently enables greater insights than the nurse is likely to engage in on his/her own (Jiang & Zheng, 2021).

CONCLUSION

Chapter 5 has reviewed my intervention of reflecting back to the research participants what they know about their leadership experiences via the use of the NPNL flower. Further, I provided an overview of the impact of using my metaphor as a reflection tool as the nurses returned to their respective clinics and captured leadership experiences in the form of vignette postcards. I described the development of the nurses as they used the metaphor to structure their dialogue around the specific NPNL dimension of identity. , I demonstrated the nurses' application of the NPNL flower to engage in forward looking leadership dialogue. It was clear that the nurses had moved from a passive stance of wanting to be informed of leadership best practices to a more active stance of continuous learning and development as they collectively, and critically, reflected on their experiences. The nurses demonstrated improved leadership knowledgeability as they renegotiated their respective identities as primary care nurses and further committed to a desire to continue to develop themselves as PMH transformation leaders.

I have shown that collaborative reflexivity enables nurses to move closer to the stretch development of further layers of petals namely collectivity, collaboration, concurrence, and

compassion or leaderful practice (Raelin, 2003). Finally, I have demonstrated the aim to continue to nurture the NPNL flower so that it will grow strong and propagate such that the PMH LoP is eventually populated with a field of NPNL flowers.

Figure 8 - NPNL Flower Propagating

This action research has demonstrated that the approach of getting nurses to use vignettes and use dialogue to critically reflect around the dimensions of the NPNL flower worked to get them to both recognize themselves currently enacting NPNL in the PMH and further, see themselves purposefully refining their NPNL. This intervention focused on identity; however, it was clear that the nurses were engaging in leadership-as-practice dialogue which included all aspects of the NPNL flower. This proof of the nurses' collective concept shows a mechanism by which we can unlock the potential of NPNL in the PMH thereby accelerating PMH transformation.

Chapter 6 provides the opportunity to bring my research questions, literature review and research findings together. I will make connections between my research findings and the existing literature which helped me to both formulate my thinking and explain NPNL. Further, the limitations of my study are addressed as are the implications for theory and practice. Finally, I provide my reflections on my research and consider the implications for my own practice.

6 CONCLUSION

As I identified in chapter 1, the central goal of primary care transformation is implementation of the Patient's Medical Home (PMH) in family practice clinics. Although the Primary Care Network (PCN) has been able to achieve success in other areas of primary care, PMH transformation has been limited. PMH transformation relies on shifting mental models and reimagining roles, including leadership roles, within family practice clinics (Howard et al., 2016). My thesis has aimed to explore the possibility of primary care registered nurses engaging in non-positional leadership to support implementation of the PMH.

Specifically, the purpose of my research was to explore how non-positional nursing leadership is enacted by registered nurses within PMHs in Palliser PCN. The central question was, how do nurses perceive leadership, and enact leadership, in the PMH? My research aimed to explore (a) the impact of role identity on nursing leadership in the PMH; (b) the impact of physician – nurse power differentials on nursing leadership in the PMH; (c) the impact of unrecognized leadership potential on nursing leadership in the PMH; and (d) the impact of lack of agreement, among nurses, regarding the nursing leadership role in the PMH. Based on my research questions, I designed a critical interpretivist action research study. I analysed data from one-on-one, face-to-face interviews, a virtual focus group, vignette documentation, and a virtual workshop.

In this final chapter of my thesis, I conclude that through developing skills of reflection and reflexivity nurses enact leadership without the pre-requisite of being in a leadership position. Further, my action-based research has demonstrated that through dialogue nurses influence the

dimensions of non-positional leadership including identity, power, social influence, and competence. I have shown that metaphor, vignettes, interactive focus groups, and workshops, support leadership development in a safe environment, which participants can then transfer to their specific leadership-as-practice (LAP) situations. Using metaphor, vignettes, an interactive focus group, and an interactive workshop I was able to demonstrate that non-positional nursing leadership exists in family practice clinics, and further that collaborative reflection and reflexivity accelerate its enactment. Finally, I have demonstrated workplace actions through which Raelin's (2003) leaderful practice may be actively pursued in the messy world (Cunliffe, 2009) of primary care nursing.

In the rest of this chapter, I review my research aims and show how my NPNL flower metaphor anchors the nurses understanding of their current leadership-as-practice experiences. Further, I show that providing time and space to consider individual and collective LAP, through use of my NPNL flower metaphor led the nurses to increasingly robust NPNL enactment. I provide a structure, based on my NPNL flower, to further develop NPNL in the PMH. Additionally, I consider the implications of my research from a theoretical, managerial, and research perspective, within, and outside, the profession of nursing. Finally, I reflect upon my growth as a practitioner and a researcher.

THE IMPACT OF ROLE IDENTITY ON NURSING LEADERSHIP IN THE PMH

Data from my initial interviews with the nurses found that many of the nurses were challenged to answer questions regarding their PMH nursing identity. Challenges with articulating their PMH

identity was associated with limited opportunities for the nurses to identify and share their common experiences (Maginnis, 2018). This issue was magnified due to a lack of primary care nursing in entry to practice education and minimal, if any, practical experience in primary care nursing prior to entering the specialty. Further, the breadth and depth of primary care knowledge, coupled with a lack of specialty training or certification, negatively impacts the nurses' sense of belonging and subsequently poor identity development (Reid at al., 2008). The challenges with identity were expanded when the nurses were asked to describe their leadership identity. This finding was in keeping with earlier research which found that nurses tend to associate leadership with a positional leader (Clark, 2008).

I had the nurses gather as-practice leadership vignettes of their choosing to work through at a collaborative workshop. The most popular vignette topic was identity. A master vignette, developed from those submitted by research participants, formed the subject matter of the workshop. The nurses interacted in a robust, energetic, and supportive manner during the workshop. The nurses voiced a level of optimism and confidence that had not been evident in their first interviews. A particularly interesting turn-of-thought occurred when the nurses identified that leadership is not a binary situation (i.e., you are either doing it or you are not doing it), rather it occurs on a continuum and is in a continuous state of evolution within the PMH. The nurses' reflections on their NPNL development are supported through concepts found in the CoP and situated learning literature whereby identity development, and active engagement in practice, leads to knowing, which in turn develops practice, which in turn leads to more complex identity construction (Lave & Wenger, 1991; Brown & Duguid, 2001; Murillo, 2011).

A potential complicating factor in identity construction for nurses in the PMH is that there is not a strong PMH nurse CoP. Nurses are likely to come to the PMH belonging to several other CoPs such as being a registered nurse, and/or perhaps belonging to a specialty group. Wenger (1998) argues that each CoP is fully situated thus learning outside the CoP will have little transferability (Handley et al., 2006). Juxtaposed to Wenger is Bourdieu's concept of habitus, which argues that individuals are predisposed, albeit through social and educational experiences, to reproduce their thinking and behaviour across contexts (Handley et al., 2006). In alignment with Mutch (2003) I found that the nurses change, across time and context (CoP) in their identity construction, level of participation, and NPNL (Handley et al., 2006).

I created a visual metaphor of a flower to reflect non-positional nursing leadership (NPNL) and its growth within a CoP. Identity is one of the dimensions, or petals, on the flower of NPNL. My metaphor helped the nurses to recognize how identity was both a result of, and influencer of, their leadership within the PMH. Further, the visual metaphor positioned identity as but one aspect of leadership that could be developed through lifelong learning, the implementation of reflection and reflexivity, and the instrument of dialogue. Providing the nurses with a metaphor to conceptualize their respective, and collective, leadership identity, combined with a safe space to engage in purposeful dialogue to articulate their iterative individual and collective leadership identity, enabled them to positively impact, and grow, their identity.

Development of identity, through situated learning with a community (Murillo, 2011; Wenger, 2004), is a powerful dimension (petal) of NPNL development within the PMH. Role identity has

significant impact on how the nurse enacts leadership. In my thesis I demonstrate that supporting nurses to understand their PMH NPNL identity as situated, and iterative, enables the nurses to experience a growing sense of co-construction of themselves, and others, as leadership participants, as well as offering insight into the malleable contexts within which their NPNL identity is being developed. Further, the concept of flower propagation, through effective lifelong learning, supported the nurses to recognize their ability to transfer their knowledge across various CoP and the LoP.

THE IMPACT OF PHYSICIAN – NURSE POWER DIFFERENTIALS ON NURSING LEADERSHIP IN THE PMH

As identified by other researchers, power and identity construction are closely tied and reciprocally influencing (Contu, 2014). Those nurses who identified themselves as enacting NPNL were more likely to also voice being able to exercise power in the relationships they have with physicians in the PMH. This is an encouraging finding as, although PMH transformation literature strongly supports egalitarian teams, this is not the norm within the PMH environment. This problem is not unique to primary care as healthcare remains hierarchical with a continuing prevalence of physicians dominating relationships (Andresen & Potter, 2017). Framing the PMH as a CoP helps us to understand and normalize this finding as, within a CoP, periphery relationships are often defined by inequality, lack of respect, and a lack of collaborative dialogue (Handley et al., 2006).

Data from the initial interviews with the nurses reinforced archaic Nightingale ideals whereby some nurses described themselves as only available to do activities as instructed by the

physician. Furthermore, many of the participants indicated that as the physicians had expertise and experience (in medicine) they had more power and the expertise to provide leadership in the clinic. These findings are somewhat disheartening to the modern, professional nurse. The profession of nursing identifies itself as an autonomous profession whereby the nurse is authorized to participate fully as a member of the health care team (International Council of Nurses, 2021). Further to this, expertise is one area (medicine) clearly does not translate to expertise in another area (leadership). The cursory acknowledgement of the need for leadership, combined with the fervent acceptance that the leadership will be provided by a physician in the PMH has not given this important topic the attention it requires. Consequently, it is not surprising that despite significant financial investment PMH transformation is not developing at the speed the government, the public, or even those working in the PMH had hoped for.

My initial interviews clearly identified existing hierarchical relationships between physicians and nurses. Use of critical action research methodology exposed the impact of the physician-nurse power differential on current nursing leadership enactment in the PMH while offering an opportunity to learn and positively impact unfolding leadership. It proved important to facilitate the nurses' dialogue such that the nurses were empowered to recognize their individual sphere of control in relation to power as well as other aspects of non-positional nursing leadership. During my focus group I reframed power from a stand-alone unit, perhaps obstacle, of leadership as simply one dimension (petal) of NPNL. Positioning power in this manner magnified it as amiable to change, among the multi-directional influence of the other dimensions (petals) of leadership. Recognizing power as existing relative to the context in which the NPNL is growing took the clout away from power as a concept. The tool to enact this change to cognition and

behaviour regarding power is dialogue. During the focus group the nurses began to articulate their use of non-positional power as a change tool within the PMH. This finding is aligned with the work Mork et al. (2010) have done regarding CoP. Mork et al. (2010) identified that at the boundaries of a CoP, such as where the respective physician and nurse CoP are scraping together, the division of work is destabilized and thus more amiable to renegotiation, reconfiguration, and change.

The focus group, enabled the nurses to dialogue, and subsequently influence, how they uniquely acknowledged, and for some even embraced, power imbalances (Vince, 2006). Several nurses shared how they engaged in dialogue which allowed them to exercise power in a given situation while avoiding conflict with the physician. This finding was in keeping with earlier research done by Radcliff (2000) and Fagin & Garelick (2004).

The safety of the collaborative focus group enabled the nurses to engage in dialogue as they collectively reflected on their perceptions of physician-nurse power differentials and the influence this has on how they view, and exercise, power as a dimension (petal) of NPNL. This opportunity reinforced for some nurses, and awakened the possibility for others, to frame power as the ability to take action, and initiate interactions, towards achieving desired outcomes or effects (Contu, 2014; Downey, et al., 2011; Urmston, 2000).

It is evident that it is not the existence of physician-nurse power differentials that is impinging on nursing leadership in the PMH but rather the nurses' mindset regarding the physician-nurse power differentials. Providing the nurses with a metaphor to conceptualize, and dialogue,

regarding their respective, and collective, mindsets surrounding the impact of physician-nurse power differentials on nursing leadership in the PMH facilitated the nurses to move from acceptance and victimization to an opportunity of growth and development (propagation) through lifelong learning (Lindemann, 2001). In my thesis I demonstrate that supporting nurses to conceptualize power, and power imbalance, as but one malleable aspect of NPNL enables the nurses to develop a growing sense of co-construction of themselves, others, and the contexts they exist in. This positioning of power engages a positive feedback cycle between power and nursing leadership in the PMH.

THE IMPACT OF UNRECOGNIZED LEADERSHIP POTENTIAL ON NURSING LEADERSHIP IN THE PMH

The nurses in my research initially described leadership in alignment with the great man theory where only a select few, in specific positions, are recognized as competent to lead others (Carlyle, 2013). Hero leadership, as initially described by the nurses in my research, espouses vision, autonomy, initiative, and passion for strategic change to a special other (Brewer et al., 2016; Collinson, 2018; Raelin, 2005). This restricted focus regarding leadership significantly limits the pool of individuals with the ability to lead. As established earlier in my thesis, the complexity of PMH transformation requires a more advanced leadership style that can capitalize on the strengths and wisdom of many. Unfortunately, a restricted view of leadership has reinforced for some nurses that they do not have a role in leadership especially where they have not been publicly recognized through a specific title.

The positioning of leadership-as-practice (LAP) is a powerful leadership alternative as it recognizes leadership as existing across many intellectual resources simultaneously through a lens of relationships, dialogue, and context. Further, LAP is empowering as it embraces the concept of personal initiative in PMH transformation. Recent research has recognized personal initiative as an indicator of competence; however, this research has narrowed the concept of personal initiative as taking charge (Zhang, et al., 2020). My research illustrated competence at a less granular level whereby the nurses engaged in reflection and reflexivity to unpack and make sense of the emergence of leadership within their specific contexts (Lord & Hall, 2005; Case & Sliwa, 2020).

In my initial interviews, the nurses could articulate the leadership value of initiative. In fact, when discussing taking initiative in patient care (sometimes referred to as advocacy) the nurses were quite impassioned. However, as their reflection moved towards PMH transformation, and change, the nurses generally became less confident in their ability, responsibility, and general competence to engage in leadership. For some of the participants, at the initial interview stage, there was a separation from initiative, transformation, and leadership noting that these aspects of competence only occur in some individuals, in some situations, with the passing of an unidentifiable amount of time.

My collaborative focus group introduced the research participants to competence as one petal in my NPNL flower metaphor. Further to this, by growing their reflection and reflexivity through collaborative dialogue the nurses developed increased awareness of the embeddedness of competence in day-to-day practice and the potential to influence it (Case & Sliwa, 2020). The

nurses' recognition of both their own leadership agency, and their ability to influence others, was in keeping with work done by other researchers. Lord and Hall (2005) noted that leadership requires meta-cognitive development that addresses both progress towards goals as well as the social factors which shape the context in which the leadership occurs. Raelin (2003) touched on this concept when describing effective collaborators as having a genuine sense of curiosity regarding the opinion/action of others, a desire to submit one's own ideas and views to the critical inquiry of others, and a view that this mutual inquiry may result in something new or unique. As the leadership potential of each of the research participants was exposed, a sense of uneasiness, and even defensiveness, occurred. This response is in alignment with the findings of Case and Sliwa (2020) who noted that recognizing ones' inherent ability to influence leadership in self, in others, and in-practice means leadership abdication is no longer an option. It was important to reinforce with the nurse participants that, although each nurse demonstrated an ability to influence their own leadership enactment, this was done in the context of my research and would not be a mandated work activity. Participation in future NPNL workshops, and/or support in critical reflection and reflexivity, may assist the nurses to develop increased comfort in leadership discovery.

Without recognizing the potential of NPNL in the PMH, it is unlikely that this resource will be utilized. In my thesis I demonstrate that a collaborative workshop, critically reflecting on self and other, re-education in the area of leadership, and development of NPNL competence helps nurses grow their leadership potential. As my workshop focused on day-to-day relational activity, it challenged the dominant leadership discourse of the nurses (Crevani, et al., 2010).

However, as shown by my research participants, this resulting discomfort serves as a motivator for lifelong learning and, further, serves to surface the potential of NPNL in the PMH.

THE IMPACT OF LACK OF AGREEMENT, AMONG NURSES, REGARDING THE NURSING LEADERSHIP ROLE IN THE PMH

My initial interviews exposed some nurses as having well-defined leadership paradigms generally founded in traditional or early post-heroic models. Alternatively, some of the nurses had significant difficulty articulating a description, or definition, of leadership. During the interviews, the nurses turned to me to either provide them with a definition of leadership and/or confirm, or deny, their definition(s) of leadership. From my ontological position of nominalism, I did not accept leadership as an entity to be defined. Rather, I was interested in the descriptions of leadership my participants used to help them engage in sense-making, or understanding, their situations and developing their knowing.

This ontological position enabled both me, and the participants, to gain new insights, and participate in action, in a dynamic and ongoing manner such that we could begin to understand the emergent realities of leadership (Easterby-Smith, et al., 2012; Raelin, 2018a). Further, by having an epistemological position of constructivism I was further driven to work with the nurses in a collective and collaborative manner to explore their emergent understanding of their respective leadership experiences within the PMH. Using language and dialogue I was able to expose the nurses' iterative understanding, and the meaning they ascribe to their leadership role, thereby answering my central research question regarding the nurses' perceptions, and enactment, of leadership in the PMH (Easterby-Smith, et al., 2012). Prior to the intervention the

nurses did not have unified language to describe their leadership role in the PMH. Further, the nurses generally saw leadership as existing in others. As such, NPNL in the PMH was ignored at best and certainly not fostered by neither the nurses themselves, nor the employer. Having a common language, as well as a framework, to describe the ongoing development of leadership, has supported the nurses to recognize and celebrate NPNL in the PMH.

In my critical action research thesis, I have exposed how the nurses link their dialogue, competence, power, social influence, and identity to make sense of their leadership within the PMH (Easterby-Smith, et al.; 2012). Further, my thesis shows how my NPNL flower enables the nurses to come to a place of collective agreement regarding their leadership roles within the PMH. This new found agreement, among the nurses, regarding their NPNL empowers the nurses to accelerate enactment of NPNL in the PMH.

NEXT STEPS IN FURTHER ENACTMENT OF NPNL IN THE PMH

The next steps for enacting NPNL in the PMH will involve development of an experiential program of knowledgeability development structured around the flower of NPNL. Participating nurses will be placed in small groups to engage in ongoing reflective and reflexive dialogue regarding their NPNL experiences, learning, and growth. Voluntary, paid participation will be sought. In other words any nurses, currently employed by the PCN, will be provided paid time to participate in the NPNL Flower program. However, participation will not be mandated by the PCN. As this leadership program is focused on critical reflection, with a goal of impacting beliefs and professional practices, (Brooks et al., 2021) it is important that the participants can engage with free will.

It is expected that the small groups will engage in a 2-hour virtual meeting monthly to develop their dialogic and reflection skills and in turn their NPNL enactment. The level of facilitation required will be determined by the group on a go-forward basis. Further, the lifespan of the group will determined by the group. Such a program will support primary care nurses to enact NPNL in the PMH such that PMH transformation is accelerated. The PCN, and other PMH organizations, can accelerate both the quantity and quality of NPNL enactment through providing formal structures to enable nurses to reflect on their leadership experiences collaboratively, and critically, within their respective PMH.

RESEARCH LIMITATIONS & IMPLICATIONS

Before considering the implications of my research for practitioners, as well as scholars, I will review the limitations of my research. I used a small sample size of 10 participants. 2 participants left the PCN and consequently the study. 1 participant left after the initial interviews, the other following the intervention and data collection. Additionally, I did not measure change over a long-time span. The post-interview intervention and subsequent data collection took place over approximately 2 months. All my participants were middle-class, Caucasian women. Although this is primarily reflective of the limited diversity of the participant pool it is unclear if my findings would be applicable across different ethnic, cultural, and economic environments. Although it is important to keep these limitations in mind, my research offers some excellent insights for practitioners and researchers, and a mechanism to accelerate the yet untapped resource of NPNL in the PMH.

Within the field of PMH research, my research may be judged as being of dubious quality related to the habitus (Bourdieu, 1990) of both nurses and physicians. Nurses who have not experienced the action of my research may be firmly entrenched in the victim role and physicians may be firmly entrenched in a power, hierarchy, and authority role. This potential response is not surprising related to the affinity of medicine, and to a lesser degree nursing, to positivism and quantitative research. I am comfortable in this position of legitimate peripheral PMH research practice. My research should be considered transformational in that it does not aim to achieve a final outcome but rather to provide a mechanism through which to understand, enact and improve nursing leadership as a means to improve PMH optimization. My action research enabled me to demonstrate that NPNL is not an ends to be achieved, but rather is a process of lifelong development of knowledgeability and improvement. My NPNL Flower is a tool to assist nurses to strengthen their leadership within their specific PMH contexts and further provides a foundation to begin the process of enacting leaderful practice (Raelin, 2003).

It is important to consider that the nurses are likely to develop a new identity, values, and norms of PMH leadership through the critical action research process (Dunn, 1999). As the nurses engage with the dialogic tools of reflection and reflexivity, they will learn to use a particular discourse. This new discourse will in turn impact how they see themselves and others (Wilcox, 1994). Engaging in reflective and reflexive conversations enables the nurses to question who they are, and how they are acting, such that they develop new ways to reframe their behaviour and attitude, and in turn, new ways of talking and acting (Cunliffe, 2002a; Anderson, 2010). This resultant self-constructed change in narrative is important to leadership enactment as

narratives influence our ability to change and learn new skills, behaviours and attitudes (Brunner, 1997). However, from an ethical standpoint, it is important to remember that transformation can be liberating, and at the same time, may be painful and/or destructive (Dunn, 1999). Attention to the well-being of the participants was imperative throughout my research and remains of utmost importance in planning implementation of the NPNL Flower program. Wellbeing is attended to by supporting collaborative reflection on how participants are feeling, critically assessing what is behind these feelings, and determining how the feelings may be amenable to change. Further, where a research participant, or future NPNL programme participant, is feeling too emotional, as self-assessed, they would be supported. The limitations of my thesis length do not permit an in-depth outline of the many forms this support could take.

Investigation of NPNL role agreement among non-nursing members of the inter-professional team would help to further understand NPNL in the PMH. Additionally, engaging physicians in critical reflection, and reflexivity, about their own leadership (both positional and non-positional) within the PMH is likely to validate the NPNL flower both within, and beyond, nursing. Common rhetoric in primary care transformation includes the concept of scale and spread. This concept has an undertone that if we just uncover the solution(s) we can apply them in other situations. Clearly, this has not been successful in my local primary care context and we need to look at new models for transformation. For this type of systemic change I propose a model which seeks to support participants to understand the complexity of the unique, unfolding, mutual relationships within a specific PMH to develop new ideas and ways of interacting (Brooks, et al., 2021). My thesis brings together a wide body of leadership, learning, and development literature, and demonstrates the ability of nurses to implement effective leadership

within the PMH without being identified as a positional leader. As I have drawn on various professional literature to inform my research it is likely that other professions, and practice environments, will find my model of NPNL to be applicable outside of the PMH and, further, outside of nursing.

My research has generated knowledge which may be applied across theory and practice. My thesis shows the ability of critical action research to unravel wicked problems such as leadership in the PMH. Further, my research helps participants identify their strengths and build on these strengths towards transformation of their environment. This iterative approach should be used in a broader capacity both within Palliser PCN and other primary care settings. As this intervention approach is guided by the participants, for the participants, it can readily be applied to other environments outside primary care and even has applicability to positional leadership. Managers will be able to use my NPNL model to support their employees in lifelong leadership growth regardless of the position of the employee in a particular organization. Application of my NPNL action research outside of western culture would be an interesting area of investigation. As this critical action research is guided by the participants critically reflecting on themselves, and their situation, it is theoretically transferable to other cultures. This needs to be tested in further research. Finally, a strength of my research is its encapsulation of Raelins' leaderful practice model. Leaderful practice stands on its own from a theoretical position. However, its application in a complex system such as primary care has been elusive. My NPNL flower provides an accessible framework through which researchers, managers, and practitioners are able to grow leaderful practice in less than perfect environments.

REFLECTION

When I began my administrative career in primary care, I was surprised with the degree I engaged with my education, and experience, in the areas of mental health/counselling and adult learning. These combined areas of expertise positioned me to have effective critical reflection and reflexivity skills such that I was able to understand that a substantial portion of my work, particularly with physicians, had very little to do with my hierarchical position. Rather, my leadership was primarily influenced by my ever-changing skills, and insight, into my engagement with dialogue, social influence, power, identity, and competence. When considering the snail pace of primary care reform, despite significant government support and financial investment, I was struck by the common theme of limited and/or poor leadership in the PMHs. As I began to read more about leaders, and leadership, I felt that the models being used for primary care leadership were inadequate. Simultaneously, I was part of a group writing national competencies for nurses in family practice. These competencies, like entry to practice competencies, identify that nurses must engage in leadership. However, being told leadership is a required competency, and having the tools to recognize, enact, and grow leadership are very different practices.

Once I committed to understanding, and supporting, the growth of the nurses' leadership enactment in the PMH, the possibilities of engaging in action research became exciting, and frightening, at the same time.

Action research was a logical fit with my area of interest as it would nurture the nurse to understand, and further develop, their own ways of knowing and enacting leadership in their

respective PMHs. It was fascinating to me that my perceptions of the respective roles of the researcher, and the participant, were rigid at the beginning of my project. I tend not to position myself as central in my day-to-day leadership; however, I had a strong sense that I would need to actively lead my participants through a reflexive approach. Partially due to this perception, and partially due to my position in the company, I spent time at the beginning of each interaction with participants explaining that my role in the project was as research student. I would not be sharing their responses with their respective supervisors or manager. Further, I explained to the participants that I was not sure how my action research would unfold. I would determine the trajectory of my research, with the participants, as we moved along in our research journey. These early discussions were difficult for me as the nurses were unfamiliar with action research and frequently asked me what I was trying to prove and/or if their responses were helping my research. My uncertainty regarding if my research would be taken seriously in the primary care LoP was concerning to me during my initial interviews. Having achieved significant academic success in positivist science I had comfort and confidence in these types of goals. However, action research was a whole new challenge. I questioned if I had the depth of intellect to achieve success in a form of science where I could not see the end goal. I experienced a change of mood, confidence, and motivation as I started to analyze my interviews. Engaging in an abductive approach allowed me to question, and find support, for my thoughts. The interactions with my thesis, my supervisor, and my participants became more intellectually stimulating and forward moving as I began analyzing my data. As I became more comfortable in my practice of AR, I slowly positioned myself, the nurses, and the system, as partners in the project each experiencing risk, potential, and ultimately gains.

I adopted a researcher role, whereby I explained action research, took responsibility for motivating participation, moving the research along, and writing the research up (Cebrian, 2020). Further, I adopted a critical facilitator role whereby I maintained a peripheral outsider role such that I was able to passively listen to participant dialogue, and proactively interject, with questions and/or suggestions as the individuals, and group, needed to establish, and grow, their critical reflexivity (Cebrian, 2020; Kember, et al., 1997). Reflectivity and reflexivity are fundamental tools for both counsellors and researchers to engage in meaningful dialogues and sense-making. From an ethical standpoint it was imperative that I ensure my research interactions did not become psychotherapeutic interactions. I did this through maintaining an internal dialogue whereby I persistently questioned myself about the value of the reflective and reflexive questions and/or suggestions I posed in terms of my action research.

My thesis positioned me, collectively, and collaboratively, to move beyond the current situation of nurses not actively engaging in leadership. Cebrian (2017) supports this type of research indicating that when we research with people, rather than on people, we are able to transform practice and ultimately achieve systemic change. Concurrently, the nurses, and I, identified change strategies and began to consider the possibility of a different future whereby nurses are not only enacting NPNL but in fact actively influencing PMH transformation through leadership. Through dialogue we were able to articulate tensions within PMH leadership and collaboratively work towards understanding and impacting these tensions in a positive manner (Simmons, et al., (2021).

When I began my doctorate, and even when I embarked on my thesis, I was tentative in discussing the science of action research. I think this is probably experienced by many neophyte action researchers. However, in my instance it is exacerbated by the shroud of positivism found in the world of medical research, where I spend much of my time. As I have learned the skills of action research, and demonstrated its value in practice, I have grown more confident in articulating the superior value action research has brought to me, my research participants and my organization.

Researching, and writing, my thesis over the last several years has been one of the most challenging experiences of my life. I had to develop discipline, dedicate time, and create thinking space to engage in the activities of my thesis, namely reading, writing, and thinking. All this, while launching 3 children into the adult stage of their life journey and running a busy company. At times I found my thesis commitment overwhelming. That said, each time I engaged in my research, either through reading journals and books, interacting with my participants, analysing my data, or writing my thoughts, I was filled with renewed passion, interest, and optimism in my thesis. On each step of my research journey, I have become more self-assured in the value of my research for my nurse participants, for the Primary Care Network and more broadly for leadership in general. Further to this, as I have moved along in my thesis, I am confident that my research will have implications for the nursing profession, the whole health system, and perhaps beyond. When I review my notes, and annotations, in my books, articles and my journal, my excitement at engaging research to support, and bring insight, to the experiences of my nurse participants is evident. My family and colleagues sometimes ask if I am not sick of being focused on the same topic for so long. It is hard to express my feelings

regarding my thesis. Although the process is arduous, each time I engage with my research topic I am filled with renewed energy, enthusiasm, and excitement regarding what my research has practically improved within my own organization and the contributions my research makes to leadership theory.

One of the most exciting turns of thought for me was when I began to uncover data, literature, and language, to support, and/or inspire, my nurse participants in their efforts to move from a place of victimization to a place of power and momentum. During my initial interviews, many of the nurses voiced a self-fulfilling prophecy whereby they only do what they are told to do. This passive behaviour, and cognition, occurs despite significant education, experience, and professional responsibility to engage in leadership. After the nurses had worked with the NPNL flower metaphor, the vignettes, the collaborative focus group and the workshop, they voiced engagement in continuous lifelong improvement valuing their non-positional leadership. I was elated during my research as the nurses began to adopt my NPNL flower as a model of their current experience of leadership and a mechanism through which they could enact and grow leadership. The nurses used the NPNL flower to bring sense to enactment of leadership without a title, and without being told by a formal leader that they have permission to engage in action.

The second exciting milestone in my thesis was seeing how leaderful practice can be grown as part of the NPNL flower. I was inspired by leaderful practice early in my thesis journey, and then was demoralized when it appeared that leaderful practice required a careful controlled environment to thrive. As my understanding of leadership as an iterative and contextualized

actor became more robust, I came to understand leaderful practice itself as unbalanced, changing, and both influencing, and being influenced by, dialogue.

CONCLUSION

A flower will bloom in any context with the right balance of nutrients as evidenced by the cactus bloom in the desert and the water lily bloom on the pond. Likewise, the unique flowers of non-positional nursing leadership will propagate where a lifelong growth of critical reflection and reflexivity is nourished. I have not only demonstrated the existence of NPNL, but I have visually demonstrated the dimensions that constitute NPNL and how these dimensions interact with each other and may be developed through the use of collaborative dialogue. Further, my thesis shows how the use of practice-based vignettes, and my visual metaphor, provide a safe environment for nurses to use dialogue to critically reflect on their in-situ experiences. My intervention created a space, in which the nurses could engage in communicative action through which they could view and value themselves differently (Kemmis, 2010).

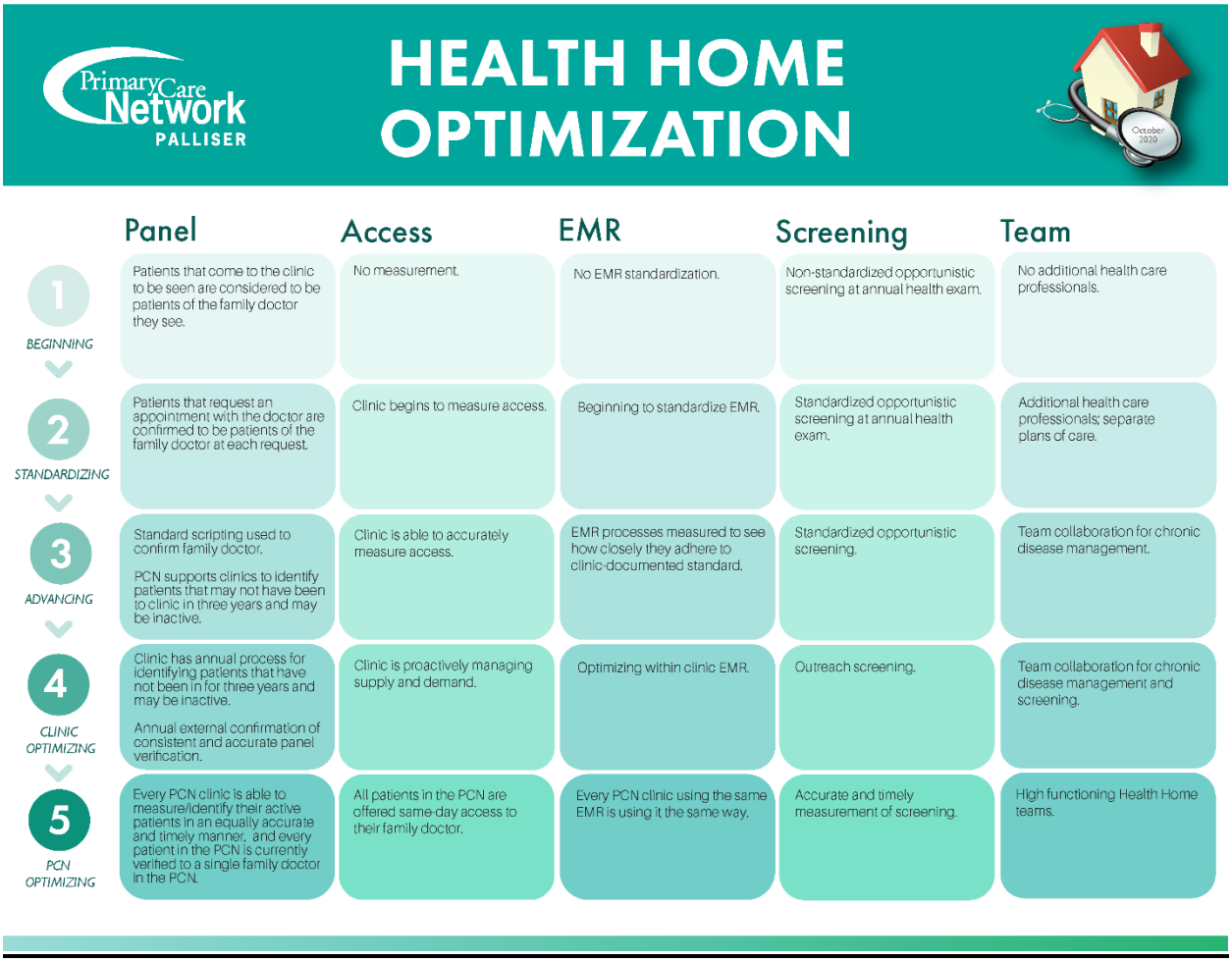
There is significant potential in my approach to move Joseph Raelin's academic ideal of Leaderful Practice from theory to praxis. I have shown that even in the messy world of the PMH where there are power imbalances, identity issues, social influence challenges, competence concerns, and manipulative or unfair dialogue exchanges, leaderful practice can be nurtured and propagated. As the petals of social influence, identity, power, and competence grow they will support further Leaderful Practice petals, (concurrent, collaborative, collective, compassionate) (Raelin, 2003).

My research is important as it provides a structure through which PMH transformation, specifically within the much needed area of leadership, may be accelerated. Transformation of the Patient's Medical Home holds huge potential economically, as well as for the health and wellbeing of the population, especially in first world countries. However, to bring PMH transformation to fruition the system requires purposeful, active leadership. A simple solution to PMH leadership has not been forthcoming as the complexity of leadership and leadership enactment within the PMH has not been given due consideration. The complexity of leadership in the PMH requires us to look beyond current leadership models and training opportunities. My action research thesis demonstrates that PMH nurses, engage in leadership-as-practice that is both individually, and contextually, unique. Further, my thesis demonstrates that providing a metaphor to ground NPNL reflection and reflexivity yields the immense leadership potential found in nurses in the PMH. Through the conceptualization of NPNL via the flower metaphor I have been able to bring dialogue to a place of centrality and a source of power for the nurses. My research has assisted the PMH nurses to bring their tacit knowledge to the forefront of thought. Finally, I have shown that through the creation of a visual metaphor to guide retrospective, and prospective, critical reflection and reflexivity, we can improve how the nurses enact leadership, individually and collectively, and further how the nurses reciprocally engage with, and impact, the PMH.

Empirically, my research contributes important new knowledge to liberate non-positional nursing leadership within the PMH. I have shown that leadership is typically not forthcoming in current PMHs. Further, current leadership models are not adequate to address the complexity of non-positional nursing leadership within the PMH. Articulating, the model by which nurses can

recognize their current LAP, as well as engage in actively shaping their future LAP, fills this knowledge gap. Additionally, through teasing out the individual LAP constructs, while clearly demonstrating their interconnectivity, NPNL is able to materialize in a more effective, efficient, and sustainable manner. Finally, my model of NPNL may easily be applied such that non-nurses, including individuals outside the PMH environment, can consider how they situationally enact non-positional leadership, and further, how they can grow, and propagate, their leadership, or neglect it until it withers and eventually dies.

Appendix 1 – HEALTH HOME OPTIMIZATION MODEL



Appendix 2 – INTERVIEW PROTOCOL

Instructions:
Good morning (afternoon). Thank you for agreeing to participate in my research project. The first part of my research consists of an interview. The purpose of the interview is to explore your perceptions of leadership within the Patient's Medical Home (PMH) in which you work. More specifically I would like to explore your leadership role within the PMH. The conversation we will be having is a reflection of your opinion. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable with saying what you really think and how you really feel.

Audio Recorder Instructions:
If it is okay with you I will be audio-recording our conversation. The purpose of this is so that I can get all the details but at the same time be able to carry on an attentive conversation with you. I assure you that all your comments will remain confidential. I will be compiling a report which will contain all participants' comments without any reference to individuals.

Consent Instructions:
Before we get started please take a few minutes to read and sign the consent form (provide participant with consent form). Once consent form is returned may turn audio recorder on and start the interview.

Demographic Questions:
What post-secondary education have you completed?
How many years have you been in practice?
How many years as a primary care/family practice nurse?
Where did you work prior to working in primary care?
How many, and what type, people work in the clinic to which you are assigned?

Semi-Structured Interview Questions:
Each interview question is followed by a number of probes which may be used in the instance where the interviewee provides a less fulsome response.

Section A: Leadership

1. What do you understand by the term leadership?
    a. In your opinion, what is the difference between a leader and leadership?
    b. What is the role of a leader?
    c. Are titles/positions synonymous with leadership?
2. How would you describe the way leadership happens within the Patients' Medical Home?
    a. How does leadership relate to your role within the Patients' Medical Home?
    b. Do you think the physician(s) you work with believe you have a leadership role in PMH transformation? Describe how you know this.
    c. What impacts how you engage in leadership within the PMH?

Section B: Identity

1. How would you describe your PMH RN identity?
    a. What shaped / is shaping your PMH RN identity?
    b. Describe how relationships impact your PMH leadership identity.
    c. What has been your biggest obstacle in developing your PMH leadership identity? How did you overcome this obstacle?

Section C: Power

1. Describe the role of power within the PMH.
    a. Describe how power and nursing intersect within the PMH.
    b. Describe how gender intersects with power within the PMH.

Conclusion

Is there anything I have not asked that you would like me to know? Thank you for your time and insight. Once I have analyzed the data, I suspect this will take a few months in light of the pandemic, I will bring the participants together as a group to provide feedback on what I believe I am seeing in the data and to help me develop next steps to improve NPNL towards transformation of the PMH within the Palliser PCN.

Appendix 3 – FIRST ORDER CONCEPT EXAMPLES

Dimension	First Order Concept	Example Quote
Identity	Embarrassment when describing nursing as a physician centered activity	It's about meeting their (the physicians) needs and making their day easier and I think we get caught up in that instead of it being about your patients. And I think the nurse gets stuck in between. When you are in the room it is about your patients and then when you step out it's about doing what my physician wants me to do and then I have to go back in the room and tell the patient what the physician wants.(P002)
	Showing self and other value in nursing practice	Degrees, or titles are huge. I mean they call him 'doctor' they call me by my first name and that is great. But I think title is a big part of that. Education everybody knows that doctors go to school for a long, long time; longer than nurses …. (P004)
	Leadership is part of PMH nursing	Nursing leadership, even though we are the leaders in the clinic I feel like even though it didn't sound like that I feel like the nurse does drive every aspect just because I suppose we are more involved with the patient and we look at them as a whole so we see all parts whereas the physicians don't necessarily look at every single area so the nurses are the leaders where it comes to the patients and their Health Home.(P003)
	Leadership is extra to real nursing	Well, in school on articles related to ethics and we would say oh that's nurse leadership. And then it was, I don't know how to label it, but there was half the year in nursing, in school like it was a fad that came up for a while and we were all like oh ya, leadership in nursing and I got that instructors advice. And she was like as students, you guys do this. We were trying to be leaders. (P002)
	Coming to terms with the business of the PMH	It's a time thing. It's much easier for a nurse for a nurse to spend half a day, much more financially feasible for a nurse to spend half a day working on a new initiative than for a doctor to take off half a day because they are not billing 30 patients or 15 patients. (P009)
	What shapes the nurses identity	The patients. Yes 100 percent the patients. Yes, I wouldn't come to work each day if it wasn't for the patients; that's what I'm there for. The pay check is nice (laughs). But, you know it is the patient that has created that identity. You know you don't have a good experience every time but just seeing how you help them through their health, their journey is what has created my identity. (P003)
	Impact of no primary care nursing experience	Ummm, nursing education I feel was more instruction based. You know you are given these orders or instructions and you follow it. You are taught how to make the bed and you follow it. You are given the list the protocol! Ya, and I don't feel like there was, I didn't realize how important, how much critical thinking came into play in nursing and surprisingly it wasn't in oncology,

		it wasn't in med surge, its more in primary care that critical thinking component is huge. And I definitely wasn't prepared for that. (P003)
	Nursing leadership is only done by experienced nurses	I definitely see experience. For the nurses that have been there a while I see like they definitely have more to offer. So I see like they would be a leader because they have more experience and they can encourage me, inspire me and educate me so I think I give them a little bit more of the title. (P002)
	Role changes over time	So I think it is definitely the clinic environment and the patients, the physicians' expectations that has dictated what my capabilities are in that office. And that has changed and evolved and grown, slowly, over time (laughs). (P001)
Competence	Iterative transformation and change	Not putting that ego of you know my clinic is the best clinic and we do everything the way it should be. I think it is taking that out of it and really honing in on is there anything we could do better. (P005)
	Pride in PMH transformation	Ya, especially after coming back after our workshops with PCN. I will come back with the most up to date resources, and new referral forms and when we had our community resource day you know I came back and we had different referral forms we were using that were outdated and so then we just, I shared those with the MOA and we let the physician know that there was new and updated forms and different things that could be changed in the EMR because those forms were uploaded when they switched over ours so. (P008)
	Leadership is taking initiative	You have to identify that gap, or that area that needs improvement, so some people might identify it but then they do push it on to somebody else and I think a leader is going to take that information and, I don't know, I guess develop a vision and then kind of help guide that vision. (P003)
	Leadership is patient advocacy	It's advocating for patients through the health care system. It is seeing a patient and trying to look at their entire, like their whole, them as a whole, it's not just a certain area. Its helping them navigate through the health care system, it's ummm disease prevention, you know its positive behavior promotion, its, all of it. Ya, it's just advocating for patients I suppose, providing the best care possible. (P003)
	Confidence as seen by self and others	That I am a novice nurse. I should sit back and listen. I have a lot to learn; more than I could teach. What I know could be summarized on a little note. All this gathered experience has a lot more to teach me than I could possibly teach them. (P002)
	Rationale for change	It's not just you know this is how I feel. So it is evidence based so, umm I feel like I have the ability or the knowledge to question and work together with my physicians. (P003)
	Lack of conviction in opinion	So a leader is, is designating a single person, and leadership is something that is assumed by anyone who chooses to partake in that behavior. I think. (P001)

	Time increases confidence due to experience and education	I feel like I am overcoming it because like I said that comfortability and that respect within the clinic grows every day. So I think it is just being okay with hey if your physician doesn't like it, it is not the end of the world. At the end of the day I think maybe I could bring it up, discuss it, is there any other ideas we can brainstorm those kind of things. I think it is maybe just being okay with it not being okay. (P005)
	Time increases leadership experience	Time to get comfortable in a role, umm, experience, if you have a lot of experience you are able to lead just based on that experience, or education, that helps as well. (P003)
	Leadership is an innate characteristic or skill	I think some people naturally have more leadership qualities naturally but I think people can over time become leaders in certain areas and I think leadership can be taught. So I think you can be taught skills to be a leader. (P003)
	Change is slow	It just depends on what it is but ah change has been slow, it has not been super-fast that is for sure. (P001)
Social Influence	Leadership is guiding the Behavior of others	I think leadership is ummm … it means someone who is, their leadership is something that is looked at to guide others. To show others the way and constantly be looking at how to improve, more forward and problem solve and its being a guide, a Sheppard. (P009)
	Leadership is behaviour	It is really hard to be in a position of leadership without having behaviors that are like a leader, if that makes sense. (P004)
	Collaborating on decisions	A leader would be collaborating with other members of the health care team to better serve the patient and doing that through working collaboratively with other health professionals; with people outside of the clinic ummm kind of just bringing everybody together for that common good I suppose. (P003)
	Feeling like you are part of the team	I think they do feel like our job does bring the patient back to the Health Home, it does, it says how do we help them navigate this system, so not frankly saying it buy maybe in a round-about way. (P002)
	Leadership is collective	we hunker down and we all kind of have a role in all aspects of leadership. (P002)
	Time increases relationship effectiveness	feel like we are in a really good setting in our clinic because we have been there for a long time and we have a lot of trust from our physicians and so they are more willing to implement our ideas. (P007)
Power	Nursing power and change	I think in terms of power I think I have the power to help bring change and make things better for patients and again that comes down to being okay with asking questions, and advocating, and that comfortability and respect. So I think there is room for all of that it is just learning to navigate how to make that happen. (P005)
	Nursing support is important to change	There are nurses that eat their own or would like to and would like to see if they can scare you out of nursing. Honestly it's really sad. Because I feel like those are the people that feel like

		they know everything. They don't know what they don't know. Those are the scary people. Those are not the team builders. They don't want to be part of the team they want to be the team. I think it is identifying those people and knowing where to put your energies and where to not. (P007)
	Physicians have power	I'm still old school where the person in authority is the physician and whatever he says you do. I do this, you know. That is what is very hard. For me to question a physician ….. that is just my personality, I grew up that way. But I don't see, I mean within the whole overall the clinic, other doctors, other male doctors they are all pretty approachable I think. (P006)
	Hierarchical roles in acute care	I can think of bazillions of times in acute care where the relationship dynamic was really different. Like whether it was like 'I'm the senior nurse and you're the floor nurse, you don't get to come to me with ideas' or 'I'm the physician and you're the nurse don't bring me protocol, don't talk to me about algorithms or pathways, this is what is being done and that is why acute care was a really bad fit for me. I think it has a lot to do with a different hierarchy that exists in acute care versus primary care ummm and a different, ya a different level of self-importance that occurs at perhaps the hospital level versus the primary care level. (P004)
	Leadership is hierarchical	Like if everybody is the leader and there is no one person, then we might all be leading but not going in the same direction so I think that leader provides us with that common goal and common direction. Like for instance for patient centered care we want the best outcome for them so that is our goal but we need somebody to be that person. (P008)
	PMH is hierarchical	It is like physician. In my clinic they are at the top of the clinic. So I put their leadership title bigger, or higher or bolder. They are the largest advocate, or the biggest decision maker or stakeholder I guess. And then I drop it down from there. The office manager, the facilitator, to us nurses, it is a hierarchy I guess. (P002)
	Gender is a factor in relationships	I don't think so. I think it is individual personality. Whatever body parts that personality happens to be in is kinda irrelevant. (P001)
Dialogue	Finding the right language to initiate change	I think you have to go about it in a way where you can demonstrate your knowledge and your critical thinking and your judgement without coming across like 'the know it all', or you know better or something like that. (P004)
	Using tentative language	Ummm, by that I mean just kind of let them guide the conversation. So, not …. Let's say I saw this patient I would say his blood pressure is this, this, kind of showing them my assessment and letting them lead that conversation. Whereas, instead of me saying I think we should start this, this and this. Like have them more guide the conversation then me direct it. (P010)

	Timing of conversations	ummmm and just if it's like the right time to bring something up and talk about it. Right timing. (P010)
	Impact of communication skills on PMH leaders	a big part of it is the way that PCN encourages you as an organization to really you know how those conversations with your physicians, and be a leader in the clinic, and try to facilitate changes and you know if things aren't where they should be or if they could be better you guys offer a lot of support and that self-advocacy portion that you don't necessarily get in the hospital environment. So I think that is a huge portion of it. (P005)
	Fear to ask questions and make changes	I think I was my own biggest barrier so just fear of the unknown, intimidation and getting past that was the biggest step. (P001)
	Watershed moments	I think it was myself in terms of not; it was until I stood up for myself and instead of sitting back and saying "I will be told what to do" coming forward and "is it okay if I just do this B12 when you are gone next week". That was all it took for me. (P001)
	Having the nursing voice heard	I feel it is much easier to be a leader in a clinic than it is in an emergency with 15 other nurses on one shift and 50 other nurses in your whole group whereas it is just me where I know I can make that change. I'm going to be listened to and respected. It might not always be the change I want but at least I feel I can put my voice out there and it will be heard and not lost. There is less noise in the way. (P005)

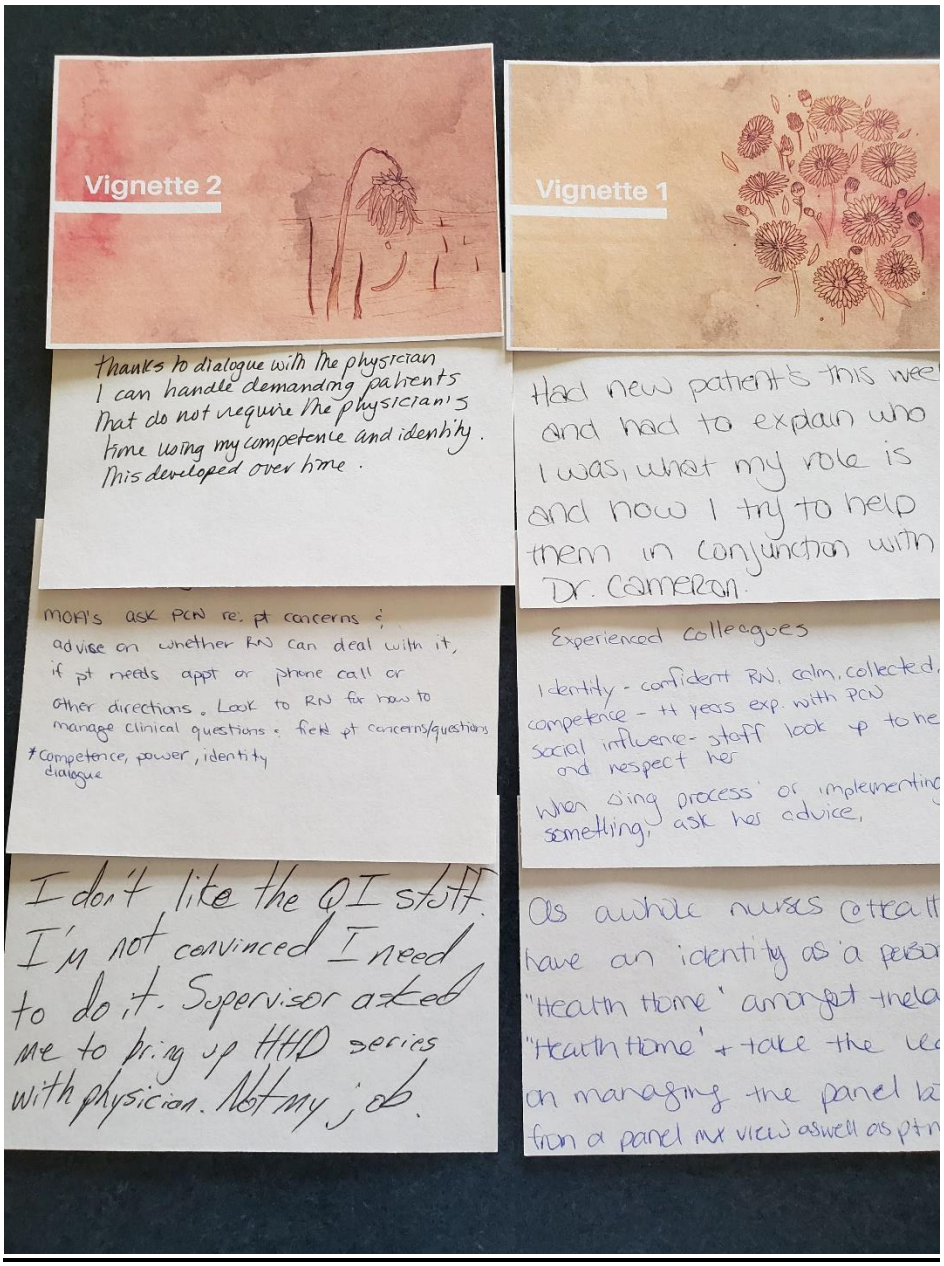
Appendix 4 – VIGNETTE POSTCARDS

Name: _____

Name: _____

Name: _____

Appendix 5 – IDENTITY VIGNETTE EXAMPLES



Appendix 6 – MASTER VIGNETTE – IDENTITY

When I first walked into my clinic to work, I felt like an outsider. Nothing in my education or experience had prepared me for the autonomy, responsibility, and isolation I would feel as a PCN nurse. On top of this the patients ask who I am, what my role is and what I am going to do for them. The patients want reassurance that the physician is not dumping them, that the physician knows what is going on, that I know what I am doing. When I have trouble with a patient I go to the doctor and he/she tells me what to do. It is challenging with patient education as the doctor comes in and tells the patient the same thing I told them: it doesn't usually work. It is challenging with practice improvement/panel work as the physician drivers/focus and the patient drivers/focus do not usually match.

Appendix 7 – MASTER VIGNETTE – POWER

Jane and Susie are both nurses at a PMH. Jane notes that physicians give orders and nurse make recommendations. Jane wonders if this is a power differential or simply a difference in roles and/or scope of practice. Susie reminds Jane that nurses actually do make orders within their own scope of practice. Jane states she uses the word recommendations as this is the word the physicians uses. As Jane is a relatively new nurse she does not believe she has the hierarchical position to change this dialogue in discussions with the physician and other PMH team members. Jane said that she has on occasion followed the physicians' medication order although she has known it is not current best practice. Susie points out to Jane that she has a professional responsibility to tell the physician there is a problem with the medication order. Jane says she wants to keep her job so she will just follow the order.

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