SCHOOL OF ECONOMICS AND MANAGEMENT
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Leading 'The' healthcare revolution in Sweden

How a broad systemic change program can be led in the professional hospital context

Course:

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We hope you will find as much joy and knowledge in this paper as we experienced writing it. Furthermore, we hope this paper contributes to the development of a sector that has been facing difficulties, especially in the last few years.

Sam den Hartog & Lorenzo de Jonge
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Abstract

Title	**Leading 'The' healthcare revolution in Sweden**
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Date	May 19, 2023
Aim	This thesis aims to analyse a planned change process at Skånes Universitetssjukhus (SUS) in Lund, Sweden. This process aims to engage the nursing staff working there, to reduce nursing staff turnover. To achieve this, the hospital opted to implement The Magnet Model (TMM) into their way of working. This model mainly focuses on leadership and structural change in the healthcare industry. By analysing this implementation from the nurse's perspective, matches and mismatches were found in their understanding. Next to this, mismatches were also identified in their needs and what this model could offer. Therefore, this study presents these mismatches with literature to help the organisation implement this change better.
Methodology	This research encompasses qualitative abductive research. While implementing three different data collection methods to generate data, which interviews spearhead the context of this study.
Literature review	The literature review aims to outline previous research in the field of change, governance, and transformational leadership.
Contributions	This paper aims to contribute to the growing literature on leadership by presenting an empirical (nurse's) view of leadership interpretation in the health sector. Furthermore, the nurse's view on leadership will be compared to the presented transformational leadership (TL) in change models. Ultimately, this will result in the presentation of matches and mismatches between the reality of the nurse's views on leadership and the academic literature in the form of a change program.
Keywords	'Transformational leadership', 'professionalism', 'structural empowerment', 'planned change', 'governance'.

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List of abbreviations

Abbreviation	Meaning
SUS	Skånes universitetssjukhus
TMM	The Magnet Model
TL	Transformational leadership

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1. Introduction

"The nursing profession continues to face shortages due to a lack of potential educators, high turnover, and inequitable workforce distribution. The causes related to the nursing shortage are numerous and issues of concern."
Haddad, Annamaraju & Toney-Butler (2023, p. 13)

Following this quote, modern-day hospitals are facing numerous challenges. To combat such challenges many methods have been tried by healthcare leaders and policymakers. Such resolutions include the reduction of errors, enforcing practice guidelines, involving patients in their care and implementation of electronic medical records. However, none have impacted any of the challenges (Porter & Lee, 2013).

As the demographic shifts towards a faster ageing population, the healthcare sector worldwide is facing major challenges (World Health Organization, 2021). This shift is a consequence of improved living conditions and accessibility to healthcare. The rapid growth of the elderly population comes with an additional increase in people with chronic conditions, of which older adults suffer more (Wu & Green, 2000). Simultaneously, the number of the working population does not increase at a similar rate. This development will lead to an increase in the need for care, whilst the conditions for the provision of skills and funding for healthcare deteriorate. The upcoming retirements will affect accessibility to such skills.

Additionally, demographic changes increase the demand for new drug development and the quantity of drugs, further driving the development costs and global spending. This leads to financial challenges in the healthcare sector. In 2020, global spending rates on prescription drugs increased by 3-6% and were predicted to increase further (Vincent Rajkumar, 2020). Therefore, the healthcare sector is forced to cut additional budgets already, which could affect the personnel within the sector. Cost reductions often lead to cost-efficient changes in work processes. Such changes affect the role of nurses and attention to patient care (Woodward et al., 1999). Rapid organisational changes in hospitals directly lead to increases in depression, anxiety, unclarity of roles, distraction, and deterioration of teamwork amongst nurses (Woodward et al., 1999). These phenomena put additional pressure on nurses, who are often already understaffed. A combination of the above could lead to a decrease in what is a nurse's most important job aspect according to a project leader of the magnet model at SUS. Namely, patient care (Persson, 2023). The most recent example of rapid changes putting nurses under

pressure occurred in 2020 when the World Health Organisation announced a public health concern.

On March 11th, 2020 WHO's concerns were put into an active statement, COVID-19 is characterised as a pandemic (Adhanom Ghebreyesus, 2020). The pandemic underlined the already existing challenges and put additional pressure on them. Extreme stress followed for the already short-staffed workforces in the healthcare sector (ASPE office of health policy, 2022). Currently, the healthcare sector is still recovering from the heavy hits that Covid-19 caused. Unfortunately, many of the preliminary challenges of the sector are predicted to persist (ASPE office of health policy, 2022). The role of governance within the healthcare sector is becoming of utter importance, but currently still lacking (Kickbusch & Gleicher, 2012), as has been proven by the pandemic.

1.1. Background

Over the last few centuries, the public sector has evolved rapidly. Especially hospitals have evolved from charitable guesthouses to scientific centres of excellence in the Western world. The evolution of the hospital is due to a variety of influences mainly existing challenges such as disease, economics, geographic locations, religion, socioeconomics and perceived needs of the population (Risse, 1999). Comparing these modern scientific hospitals to traditional hospitals, as described by academic literature, differences become apparent. This traditional view highlights the *Hippocratic oath*, an oath physicians had to swear not for their precepts of medical **professionalism** (Bhardwaj, 2022). This oath emphasized all professionals should do good (beneficence), the obligation to not harm patients (non-maleficence), and should remain confidential (Askitopoulou & Vgontzas, 2018a, 2018b). The professionalism of traditional hospitals was further emphasized by the nursing staff, referred to as 'general duty nurses' (Penn Nursing, 2023). Within traditional hospitals, this division or 'governance of professions' was of great importance for the efficient operations of the hospital (Penn Nursing, 2023). This professionalism contained certain elements of hierarchy as by tradition physicians were more educated and obtained more authorisation than other professions within the hospital (Bhardwaj, 2022). However, often a **horizontal aspect of organising** was maintained for efficient operations as all healthcare staff was professionalised in a different area. This aimed to increase the horizontal coordination of the hospital, as all professionals focus on their core activity working alongside and with each other (**collegialism**) to ensure **patient care**. With influences changing the hospitals further,

the healthcare sector became increasingly more complex, further developing the importance of safety, effectivity, patient centralisation, time, and efficiency (IoM, 2001).

In the 1970s, a new revolution doomed over the horizon, managerialism. This new concept was not unknown to the world but was relatively new to the public sector. Broadbent and Laughlin (1998), name this new concept New Public Management. This new concept was conceived as *"an identity-discrepant cue for a managerial logic"* (Meyer et al., 2014, p.873). Which places a high focus on the recording of, performance measures, efficiency, and accounting tools. These new implementations of measurement were to be overlooked by new managers in new roles. Thus, introducing a top-down imposed organisation through "tick-box" compliances indirectly eliminates the changes for changes (Broadbent & Laughlin, 1998). Hood (1995), mentions three main elements that came with this revolution; additional highlighting on visible hands-on top management; explicit focus on measurement of standards, performance, and success; and more emphasis on output controls. Summarizing these with the term 'Accountingization' (Hood, 1995). In terms, this led to organisations becoming **more bureaucratic**, **a focus on managerialism** (thus becoming **more vertical**), and in term resulted in **less focus on the core activities** (Alvesson & Sveningsson, 2011; Hood, 1995; Meyer et al., 2014; Spanò, Tomo & Parker, 2021). In the study from Bourgault and Van Dorpe (2013) that healthcare organisations, that belong to the public sector, are now more individualistic, have more fixed-term contracts and focus more on accountability.

1.2. Challenges

From the shift presented above, challenges arose in the sector. The employees became more and more frustrated with the hieratical systems introduced since the increased heterogeneity of the workforce in the sector lead to a greater form of complexity of the collaboration between employees (Spanò, Tomo & Parker, 2021). Modern hospitals have adapted their traditional horizontal structure to that of a bureaucratic vertical structure (Magnusson, 2023). This structure is explained through the metaphor of a tube system. This implies that departments only actively communicate within their tube. Additionally, the tube systems result in high levels of hierarchy in which the low-level personnel are limited in decision-making. This causes a time-consuming process of decision-making in which personnel is already faced with time pressure. Therefore, when the need for communication between tubes occurs, this proves a rather difficult process (Persson,

2023). As can be read in the previous chapter, a shift from collegialism to bureaucratic managerialism has resulted in a hierarchical dependency structure where lower-level personnel feel less inclusive (Broadbent & Laughlin, 1998).

Additionally, the shift of structure has affected the core activities of the personnel in such tubes, shifting personnel away from patient care. With the rise of managerialism patient care activities were limited and replaced with more focus on accountability and administrative tasks (Alvesson & Sveningsson, 2011). These non-patientcare focussed tasks now tend to fall under the job description of physicians and nurses. In the last few years, it has become clear that the increase in administrative tasks has led to a decline in participation rates amongst healthcare staff. Moreover, this decrease in motivation has been linked to higher levels of stress and burnout (Erickson et al. 2017).

These challenges identified in the shift to managerialism together with the ongoing issues the healthcare sector is facing (1. Introduction), have stretched the healthcare personnel quite thin. As mentioned, nurses feel unmotivated, which results in many choosing not to continue to work in these conditions. Since this would be catastrophic for the sector which is already suffering from a shortage of knowledge workers (Alvesson & Sveningsson, 2011; Bourgault, 2022), changes had to be made. Please refer to Figure 1 below for an overview of the beforementioned challenges.

Challenges	**Explanation**
Bureaucracy	Modern hospitals maintain a vertical top-down structure
Limited communication	The tube-system limits communication outside of the tube
Less inclusivity	A combination of hierarchy and limited voice has resulted in less inclusivity
Less focus on core activities	Managerialism has resulted in increased administrative tasks. Simultaneously decreasing the amount of patient care
Declining motivation	All these challenges cause stress for nurses thus leaving them unmotivated
High staff turn-over	All the challenges above have resulted in nurses leaving or changing ship

Figure 1: Reasons for change model

1.3. Solution

"*In modern ages we are still facing the same issues that we faced when nursing really took off*" is a quote from the podcast by O' Grady (Another Living Legend - O'Grady Discusses Professional Governance, 2022).

Changes had to be made in the sector, since, as stated above, the same challenges are still present in modern ages. Since nurses operate organisation-wide, these challenges influence the organisation as a whole (Porter & Lee, 2013). To address this, changes must be organisation-wide. This is advised to do in the form of a broad systematic model, which tries to cover many organisational aspects (Alvesson & Sveningsson, 2015). The idea is that the process of change should be systemic and that it is essential to match the "softer" components of people, leaders, and values with the "harder" parts of technology, strategy, and structure (Beer & Eisenstat, 1996, cited in Alvesson and Sveningsson, 2015). Many of these all-encompassing models have been suggested, and all focus on how to improve efficiency organisation wide, like the 7s Model by McKinsey (Thomas J. Peters & Robert H. Waterman Jr, 2006). One of these models was centred around nurses, thus changing the broad organisation to complement them.

In 1983 a study by the American Academy of Nursing was conducted, aimed to identify the characteristics of healthcare organisations that excel at the recruitment and retention of nurses (Wolters, 2022). Based on this study, the Magnet Recognition Program was launched, this recognition award was only given to hospitals that entailed all the criteria deemed best for nursing practice and innovation (Gagnon, 2021). Within these institutions: "*nurses are empowered to not only take the lead on patient care but to be the drivers of institutional health care change and innovation* (Gagnon, 2021)."

This program aimed to set up a tool used in hospitals that want to change to become more attractive for nurses to stay close to, The Magnet Model (TMM). TMM consists of five components (The American Nurses Credentialing Center, 2017);

1.Transformational leadership

TL surpasses the requirements for stabilisation and growth by focussing on changing organisational values, beliefs, and behaviours. Therefore, TL requires vision, influence, clinical knowledge, and strong expertise. Furthermore, TL acknowledges potential turbulence and involves atypical approaches to solutions. To achieve solutions, listening, challenging influence and affirming a way to the future are of the essence.

2.Structural Empowerment

Through structures and processes, this model creates an innovative environment for professionals to excel and achieve outcomes. Collaboration in this element is key to achieving this and ensures the best patient outcome. Staff needs to be empowered to achieve these organisational goals. Thus, ensuring that nurses maintain magnetic to the organisation.

3.Exemplary Professional Practice

The goal of this component is to empathize with the professional element of the of the nurses. With focusing more on the establishment of strong professional practice, than it is what that professional practice can achieve.

4.New Knowledge, Innovation & Improvements

The three earlier stated elements form the building blocks for magnet organisations. Namely, to have ethical and professional responsibility to contribute to the patientcare, the organisation, and the profession in terms of knowledge, improvements, and innovation. These elements will contribute to the organisation through the creation of new evidence and visibility of contributions in the science of nursing.

5.Empirical Quality Results

The primary focus of TMM is on changing structures and processes to realise a good outcome. As TMM has no specified outcomes due to a lack of data, an increase in the quality of care can be seen as a good outcome.

The components are build-up out of Forces of Magnetism, thus attracting nurses. Maintaining the five pillars allow for nurses' empowerment, decision-making and boosting of morale, which in turn will lower the high turnover rates in the industry (Grant et al., 2010). Please refer to Figure 2 for an overview of the model.

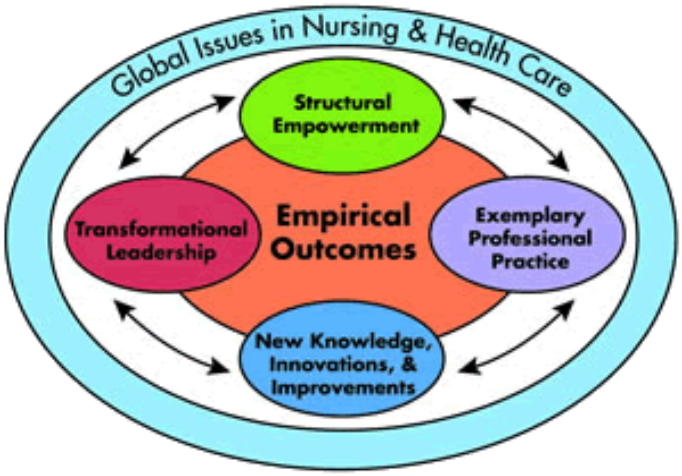

Figure 2: The Magnet Model

In turn, this model should on paper tackle many of the before-mentioned challenges by focusing more on the main tasks of nurses, thus ensuring collegialism amongst employees. With the focus being more on professional traits, administrative roles are reduced. Lastly, all these elements should be included with the idea of a transformative leader. However, questions arise about whether such a broad systemic change program promotes the idea of the professional and complex setting of a hospital.

1.4. Research problem

This research finds its origin in the healthcare sector in Sweden, more specifically at SUS. The hospitals employ over 12,550 employees distributed over 25 different departments. SUS is currently facing similar challenges as the health sector as stated above. Therefore, the organisation has opted to undergo planned changes in which the hospital wants to retain more nurses to the hospital. Thus, it opted to implement a broad systemic change model into its undertaking. *"Therefore, as being the main model to reduce this aspect, we also opted to go on the Magnet journey"* according to Ms Magnusson (2023) (TMM project coordinator). This American model aims to reduce nursing turnover in the sector.

Terminology at SUS

Big organisations are prone to creating their own terminology (Young, 2020), SUS is no

exception of this rule. Please find below figure 3 with the organisational jargon of SUS.

Jargon	**Meaning**
Unit	A unit refers to an area of the hospital where a specific practise is performed. Units can be small in scale (2 beds) but also comprising a multitude of beds.
Ward	See Unit.
Clinics	Refer to a department in the hospital, for example Osteopenia, which could consist of multiple units.
Change leader	A change leader is responsible for helping the change being formed. These people are there to ask questions and have generally the most knowledge for the implementation of The Magnet Model.
Change coordinator	The change coordinator is the person who holds the highest rank in the change process, being end responsible this person oversees the whole change.
Project leader	A project leader is the person responsible for the changes within the wards, these people transfer the knowledge to the rest of the team.

Figure 3: Jargon list SUS

Due to the complexity of understanding leadership and decision-making regarding change implementations, the hospital needed enthusiastic researchers to identify challenges as patterns in these elements. Therefore, this research focuses on two pillars of the model, namely the impact of TL and how structural empowerment influences the organisation. Additionally, as few literatures discuss TL in practice, this research contributes to the already existing literature by providing empirical findings on TL in practice. This research aims to contribute by providing a representative view of the challenges and needs of employees in the healthcare sector, and pedagogically analysing if the model will resolve these. Therefore, this research aims to answer the following question:

How can a change program based on a broad systemic model containing elements of managerialism be led in the professional context such as a university hospital based on collegial coordination?

From a research perspective, it is deducted that issues in both the sector and at SUS actively contribute to a high staff turnover. As stated, SUS believes that TMM will aid in

reducing these challenges by offering a set model. However, when changing, new challenges arise (Nohria & Beer, 2000).

1.5. Outline

This research focuses on the empirical depiction of a systemic broad change program in the form of TMM. The research aims to contribute by providing a representative view of the challenges and needs of employees in the healthcare sector, and pedagogically analysing if the model will resolve these. Additionally, contributes to the current academic literature on TL in practice. Consisting of six chapters, this research aims to analyse the earlier stated research question. The introductory chapter provided the reader with an overview of the healthcare sector, followed by the problematization and the conducted research question. The follow-up chapter presents the literature review. Here, relevant literature will be drawn upon to create a better understanding of what is already known regarding the topic. Later, this literature will be placed within a healthcare sector context. The methodology chapter provides insight into the methodological approach, justifying and explaining the data collection and analysis. Additionally, the credibility aims to provide a sense of truthfulness in this paper. Chapter 4 presents the findings of the collected empirical material, followed by the researchers' interpretations. The findings from the previous chapter will be discussed alongside the literature review in Chapter 5. The emphasis lies on adding additional interpretations to the already existing literature. The final chapter provides a summary and conclusion of the main findings of this research, to answer the intended research question, alongside limitations of this research. Furthermore, the research aims to provide additional recommendations to SUS, make a theoretical contribution to the already existing literature, and make suggestions for future research regarding this topic.

2. Literature review

This chapter aims to create a theoretical background for the problems presented. The goal of this research is to contribute by presenting a representative view of the needs and challenges faced by employees in the healthcare industry and analysing pedagogically whether the model will address these. This paper pays close attention to organisational change and the sensemaking of changes in the health sector. In the upcoming sections, an in-depth view will be presented wherein the researchers refrain from using an all-embracing view of the literature, as only the most significant are presented. Please find an overview of the Contextual structure of the research in Figure 4 below.

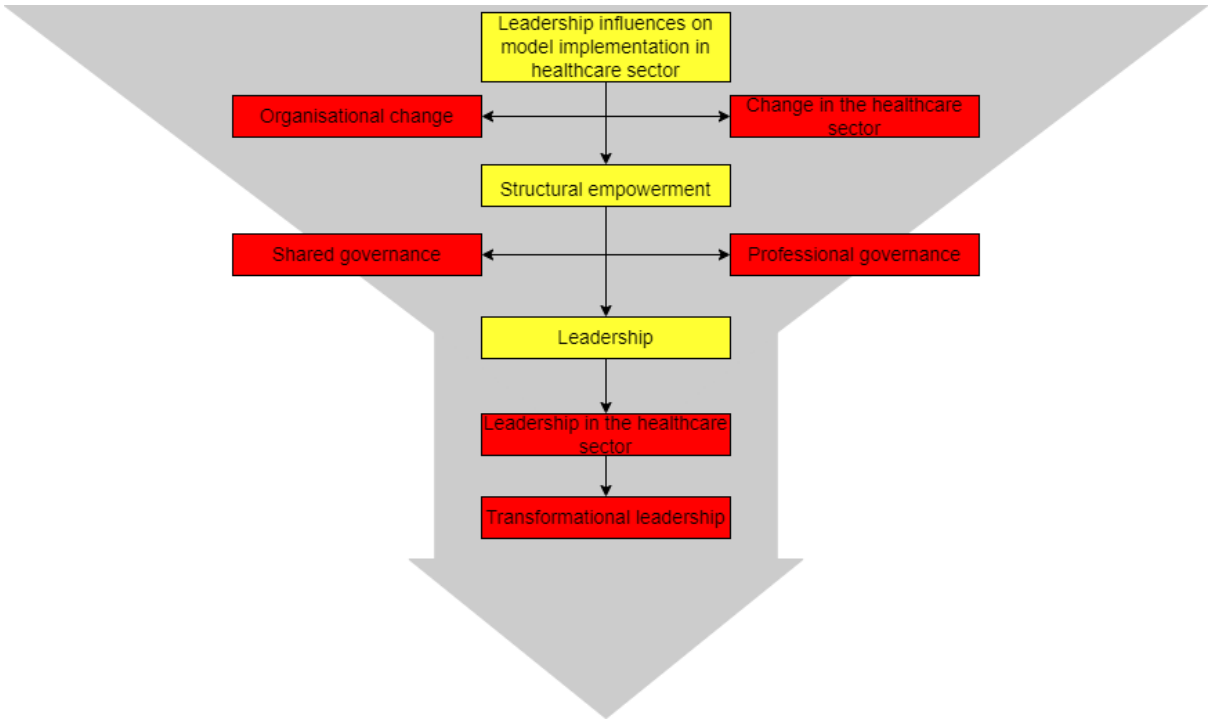

Figure 4: Contextual structure of literature review

As can be seen in the contextual structure above, this literature review identifies three main themes for the review to focus on: Leadership influences affecting the implementation of a broad systemic change model, Structural empowerment, and Leadership. All links to the main industry, the healthcare industry. The review takes a step deeper into the literature with each subject, until transformative leadership, more specifically, in the health sector is explored.

2.1. Organisational change

Organisations are complex systems, constantly evolving causing organisational change to be as inevitable as death and taxes (Palmer, Dunford & Buchanan, 2016; Sveningsson & Sörgärde, 2023; Weick & Quinn, 1999). However, like taxes, the process can be quite difficult to follow and does fail often (Nohria & Beer, 2000). Organisational change is the process of altering a business' structures, procedures, and culture to boost total performance and competitiveness. It involves changing the organisation's existing structures and practices to better align with its goals and to adapt to its shifting internal and external contexts (Palmer, Dunford & Buchanan, 2016).

As stated, changes to the organisation are inevitable, however, these changes can either be planned or unplanned (Palmer, Dunford & Buchanan, 2016). Pierce, Gardner and Dunham (2001) name these two reactive and proactive changes. Herein the reactive (unplanned) changes occur from external and internal forces in the organisation, whereas proactive (planned) let the organisation make the changes in advance. Kotter (2012) states that organisations either change rapidly or perish, while on the other hand, it is advised to avoid the risk of implementing too much change all at once (Bruch & Menges, 2010). Sometimes changes are needed that entail the whole organisation, such changes often are in response to the need for greater organisational flexibility in response to external turbulences (Balogun & Johnson, 2004). These kinds of changes are identified as broad systemic changes.

It may make sense to implement a broad systemic change program since it addresses a variety of organisational aspects, but doing so is also difficult because it necessitates that all the model's dimensions (or subsystems) be properly aligned with one another. Numerous authors (Alvesson & Sveningsson, 2015b; Balogun & Johnson, 2004) argue that broad models are essential since changes frequently affect several linked organisational aspects, but as was previously stated, this also necessitates that the model's various dimensions be internally well aligned. To achieve this, communication is deemed crucial for the success of these models (Thomas J. Peters & Robert H. Waterman Jr, 2006). A broad systemic change model presents additional difficulties since it necessitates a radical transformation of the circumstances in which it is used. A professional organisation, for example a hospital, has many unique characteristics, making a radical model's requirement for radical change in the local context hard. However, the question remains how this type of change upholds in the professional context.

Looking at the characteristics of an organisation is crucial and deciding how and why one must change. These changes occur when forces from both internally and the environment render the current organisational strategies or design obsolete, thus threatening the very existence of the business. Tushman, Newman and Romanelli (1986) conducted a large study of organisations that entered transformative changes and concluded that these occurred in response to (Tushman et al. 1986 cited in Cummings & Worley, 2009):

1. **Industry discontinuities**—sharp changes in legal, political, economic, and technological conditions that shift the basis for competition within an industry
2. **Product life cycle shifts**—changes in the product life cycle that require different business strategies
3. **Internal company dynamics**—changes in size, corporate portfolio strategy, or executive turnover.

These changes force organisations to partake in major changes in the vision, culture, structure, and systems. This is in line with Weick and Quinn (1999) who state that to move forward big changes are necessary. However, in the research from Moore and Buchanan (2013), it is seen that when organisations, try to fix small issues fast, the performance improvements were significant. According to Palmer et al. (2016) this way of performing change, allowed the organisation to establish platforms (mostly in the form of employees) from which to build further, thus, enacting deeper change initiatives from shallow changes.

Employees have a big say in the success of organisations (Potnuru, Sharma & Sahoo, 2021), change does not happen without the support of the other. In the work of Yan et al. (2022) it is stated that the view of transformational change by workers is seen as a source of work-related stress, which may lead to psychological stress reactions in response to employee behaviours. These transformative changes affect on the workforce, however making sense of a situation can reduce these ambiguities (Thurlow & Helms Mills, 2009). Jones et al. (2008) emphasise that the role of executives and/or supervisors play the most important role in letting changes run smoothly.

For successful change to occur, understanding the process is of the essence. A mutual understanding can only occur when both sensemaking and sense-giving activities relate to each other in a specific context (Hislop, Bosua & Helms, 2018). However, everyday sensemaking does differ from organisational sensemaking. The development of an appreciation for ways to conceptualise organisations and their environment is crucial for

organisational sensemaking (Weick, 1995a). How sense is made depends on the type of organisation and the system it maintains. Scott (1987) defined organisational systems in three ways: Rational (pursuit of specific goals and containing highly formalised social structures), Natural (share of common interest and informally structured collective activities), and Open (Coalitions of shifting groups who develop goals by negotiation, of which the outcomes are strongly influenced by environmental factors). Although, all organisations consist of people with shared values and beliefs participating in habitual work processes, not all organisational systems allow for sensemaking (Weick, 1995a). Looser systems are more open towards environmental factors, allowing for diverse information to enter the organisation (Weick, 1995a). Therefore, organisations that maintain a rational system, will often have lower levels of sensemaking than organisations in an open system. Based on the above it becomes clear that context and organisational systems have a high influence on the levels of sensemaking, affecting the change process with it. These contexts are crucial to identify the type of changes necessary and should be taken into account, one cannot rapidly change a closed system (Weick, 1995a).

Change in de health sector

The healthcare is generally seen as a closed and professional system, making room for own interpretation difficult (Gray, 2017). Due to its rigid structure, a closed system cannot adapt fast and is not flexible. When a company has a closed system, communication between levels of employees is linear, which forbids staff from acting outside the set order (Marquis & Huston, 2011). Closed systems can also be described as a "machine bureaucracy" (Mintzberg, 1992), both focussing on vertical decision-making and a formal accountable structure. However, according to Mintzberg (1992) such a structure can lead to some vertical departments becoming too specialised, thus distancing themselves from the organisation. When this happens a form of "professional organisation" is suggested, putting the emphasise on the professionals their decision-making, thus being more flexible to sudden changes (Mintzberg, 1992). This is evident when such a sector has to change rapidly, e.g., the COVID-19 pandemic is a big example of such a transformative change (Deloitte, 2023).

In general, the health sector is a difficult one when it comes to implementing change (Al-Abri, 2007). The health sector is adapting rapidly, with incremental developments in the fields of science and technology, becoming harder and harder to keep up (Longenecker & Longenecker, 2014). In a study conducted by IBM (2023), it is stated that the health sector is moving towards a world where both doctors can conduct drastic surgery, and nurses can analyse and keep track of patients, from home. These are all anticipations for

the challenges the healthcare will face like the ageing population depleting the number of doctors and nurses while at the same time putting more pressure on the already stressed workforce (Dye, 2017). However, this change process is slow, takes time and is not universally implemented.

In a study by Longenecker and Longenecker (2014), the few factors leading up to change failures in the health sector were analysed. The top three identified are; *1) poor implementation planning and overly aggressive timelines, 2) lack of trust in management, and 3) ineffective top-down communication.* The first factor mentions that, like most change initiatives, the change failed because of a lack of planning (Kotter, 2007). However, the difference here is that the health sector, belonging to the public sector, wants to implement changes quickly (Longenecker & Longenecker, 2014; Moore & Buchanan, 2013; Wright & Pandey, 2010). The main reason is poor implementation planning, with unrealistic goals.

> *"[…] change initiatives in healthcare organisations fail to achieve desired outcomes because of their implementation is poorly planned and the proposed time frames for implementation are overly aggressive."*
> (Longenecker & Longenecker, 2014, p.7).

These lead to negative outcomes and are mostly just based on models or tools from the best practices, which 'should work' in all similar organisations (Longenecker & Longenecker, 2014; Moore & Buchanan, 2013).

The second factor is identified as a lack of trust in management. The study from Longenecker and Longenecker (2014) shows that in the healthcare/hospital environment leaders are not seen as the leaders they want to be, but are mostly associated with terms such as: "bureaucrats", "sycophants," "politicos," or "butt-kissers"(Longenecker & Longenecker, 2014). These leaders become even further counterproductive when the organisation is undergoing rapid change. Michaud et al. (2011) give one reason for such accusations to be made, by stating that management in hospitals in Europe does not mandate management to have a nursing or medical background. This in a sense creates unrest under the followers who find it difficult to follow someone who does not 'know what he/she is talking about' (Dye, 2017).

The third factor is focused on the communication aspect, which in general is one of the main elements for change to fail in organisations (Leonard, Graham & Bonacum, 2004). When changes are imposed, an extensive and intense two-way communication process is

required, ensuring that everyone is informed of the proposed changes, this is different from what normally happens (Palmer, Dunford & Buchanan, 2016). Even though one-way top-down communication does have the advantage of delivering the news quickly and easily, this does leave ample room for creating understanding in the organisation. Such an approach is most apparent in hospitals as it is the 'quick and dirty' way to get information across in a public organisation, excluding involvement in the decision-making (Nguyen, 2020). This was emphasized by Longenecker & Longenecker:

"It seems like we are in such a hurry all the time that it is easy to not communicate as well as we should ... and we only create problems for ourselves in doing so"
(Longenecker & Longenecker, 2014, p.11).

Many factors contribute to change failures in general. However, in hospital change failures can be contributed to ineffective leadership. Along with, an absence of well-established and fundamental principles of change management (Longenecker & Longenecker, 2014). Furthermore, although some of these issues have been raised in the past (Bazzoli et al., 2004; Mccann, Graves & Cox, 2014), they are now more urgent due to the hyper-dynamic nature of the healthcare environment. It is argued that the health sector should implement a more open system environment to minimise the effect these changes have.

2.2. Structural empowerment of the healthcare sector

Now that needs in the healthcare sector have been addressed, this sub-chapter focuses on the specific change that comes with the implementation of TMM. As discussed in Chapter 1, TMM exists of five pillars that contribute to the reduction in nursing turnover. The pillar of 'Structural empowerment' focuses on the empowerment of staff to achieve organisational goals collaboratively. TMM addresses the lack of involvement as one of the primary challenges in modern-day healthcare. Today professionals are limited in their decision-making within their profession. Through structural empowerment, lower-level personnel will be involved in decision-making, allowing them to get their voices heard in a current top-down communication structure. This concept is known as governance and ultimately aims to return decision-making to the professional (The American Nurses Credentialing Center, 2017). TMM addresses two variants of governance: Shared and Professional. Both variants will be discussed below.

Shared governance: involvement in decision-making

As can be seen in the chapters above, the health sector is faced with a lot of different challenges, all adding to the presented problem of a high nursing turnover. This problem originates from the link between employees and businesses (Porter-O'Grady, 1995). The link between the two has been seen in many philosophies e.g., Kanter (Laschinger & K, 1996), Maslow and Drucker (Porter-O'Grady, 1995). These philosophers argue for a shared form of governance, since the success of any system depends on investments, commitments and ownership by stakeholders that are located closest to the point of service (O'May & Buchan, 1999).

This idea of shared dependency however has only been lately introduced to the nursing field, with the first US hospitals introducing the concept in the late 70s/ 80s (McDonagh et al., 1989). The idea originated out of dissatisfaction amongst nurses, not about nursing itself, but more about the hospitals they practised this craft in (Another Living Legend - O'Grady Discusses Professional Governance, 2022). Therefore, it is more to be seen as a method to support the delivery of nursing care, instead of a radical new design (Schaffner & Bouman, 1992). From here it can be concluded that it is an idea of thinking, sharing the decision-making process. O'May and Buchan (1999) mention that shared governance is the idea of a decentralized approach aimed to give nurses control and more authority over the work they are doing. This is with the initial aim to aid the relationship between the patient and service provider (nurses). Porter-O'Grady (1995) sees the phenomenon not as a one-time implementation, but more as a streamlined journey, without an outcome.

Shared governance has been developed heavily in recent years, with more and more models being adjusted to the shared style of decision-making. Barret et al. (2019) mention four types which are most prominently described in the literature: congressional-, councillor-, unit-based- and administrative forms of shared governance. Below an overview of the named forms of governance and how these influence organisations are presented:

Unit-Based	**Congressional**
- Each unit establishes its own system - Multiple models may exist within one institution - No department-wide co-ordinating activities	- All staff belong to a congress - Similar in structure to federal government - Committees submit work to "cabinet" for action
Councillor	**Administrative**
- Co-ordinating council co-ordinates activities on department level - Unit councils reflect department councils - Staff nurses accountable for clinical decision making	- Practise and management structures exist - Forum integrates work of councils - Councils submit work to executive council for decisions

Figure 5: Different forms of shared governance (O'May & Dunchan, 1999, cited in Barrett et al., 2019)

Herein, Unit-based shared governance has the advantage of being a more direct way to communicate, while sacrificing the advantage of including more of the organisation in the decision-making process. While the others are focused on the establishment of councils for decision-making, which is the prime idea of shared governance (Porter-O'Grady, 1995).

There have been multiple reasons given why shared governance should be implemented. Kovner et al. (1993) mention that the shortage of nursing staff is mostly linked to the fact that nurses do not, feel that they have any autonomy in practice, get paid enough, and result from poor working conditions (Deremo, 1989). These are mainly caused by the highly bureaucratic hospital systems. By giving nurses control and authority over their practice, shared governance has been proposed as a solution to the perceived bureaucracy issue (Porter-O'Grady, 2001). Thus, reducing the highly top-down organisations in the healthcare sector.

However, such changes will increase the amount of work for the nurses e.g., in their planning, decision-making, and establishing of priorities. Nurse executives must somehow deal with financial management concepts and practices (Dowd, 1988). Decisions about how to allocate resources must take community requirements, patient care, and service quality into consideration (O'May & Buchan, 1999). Therefore, another

form of governance is discussed, being more focussed on own decision-making and responsibility in routine work, namely professional governance.

Professional governance: Ownership of decision-making

Professional governance is a later developed structure in a quest for excellence that provides solutions to the decentralised independent operational models of shared governance (O'Grady & Clavelle, 2021). One such operational model is the inclusion of employees in decision-making as a key concept of shared governance (O'Grady & Clavelle, 2021). However, the ultimate authority of decision-making still often belongs to board members and higher-ups causing challenges in decisions that may lead to conflicts (Holley & Tierney, 2006; Honu, 2018; Pierce, 2014).

The foundational work on professional governance aimed to resolve the lack of challenge of the hierarchical or bureaucratic infrastructures in shared governance. This was done by outlining organisational structures applicably within any clinic (O'Grady & Clavelle, 2021; Walker, 1986). The applicability of the structure derives from the emphasis on individual action taking amongst employees. In professional governance, all deliberations, mechanics, processes and actions come from employees themselves (Office of the Superintendent of Professional Governance, 2019; O'Grady & Clavelle, 2021). In terms of decision-making, this means that the shift from shared governance to professional governance creates ownership of decisions. Employees are no longer participating in decision-making but hold ownership over their own decisions. Furthermore, engagement and accountability will make place for demonstrating how individual decisions will provide value for relations in the entire network (O'Grady & Clavelle, 2021). Additional value can be found in the relationship between accountability/ownership of decision-making and performance, as accountability-based management can improve performances in public organisations (Han & Hong, 2019). Nonetheless, concerns regarding accountability are of the essence as it may be a significant source of stress as well (Shernoff et al., 2011). Most importantly, academic literature discusses that effective/good governance practices can only be implemented when the organisation improves its organisational culture (Abdelaziz, 2022). However, how this academic literature holds up in practice remains unknown as professional governance in practice remains a topic that needs additional research.

The role of governance is becoming significantly more important in the medical sector due to government control exercising power shifts, affecting healthcare employees in serving the interests of citizens (Kuhlmann, Allsop & Saks, 2009). Similar to most forms of governance, professional governance is majorly targeting the healthcare sector, more

specifically nurses. Professional governance aims to position nurses in a legitimate structure where they are allowed to take control (O'Grady & Clavelle, 2021). Additional attributes are in place to support the nurse's locus of control (Porter-O'Grady, 2001). The locus of control regards to content as practice-based, quality/evidence, competence and knowledge-driven actions (O'Grady & Clavelle, 2021). When these attributes are implemented correctly, it can be described as good/effective governance according to academic literature. Following Abdelaziz's (2022) definition of good governance, good governance leads to improved accountability, encourages participatory processes, promotes inclusivity and contributes to better resource management.

However, good governance also comes with challenges given professional governance's individual-focused work environment. One such challenge poses itself as leadership. Leading such an individual-driven work environment can prove difficult due to everyone maintaining their own approaches planning, implementations, and evaluations. This sparks the question of how such an individual work environment must be led.

2.3. Leadership

The second pillar this research focuses on in TMM is centred around leadership. This chapter will elaborate on leadership in general, followed by the specific type of leadership that TMM elaborates on, Transformational Leadership.

Leadership has become an increasingly interesting topic of a vast literature, diversifying itself among endless social sciences and the humanities (Alvesson, Blom & Sveningsson, 2016; Marturano & Gosling, 2008). Where traditional/classic literature on leadership focuses on the supervision of subordinates, modern literature targets broader and more abstract organisational challenges of leadership (Alvesson, Blom & Sveningsson, 2016). It is commonly believed that leadership can have a significant impact on organisational operations (Alvesson, Blom & Sveningsson, 2016; Yukl, 2012). However, even though there are many different leadership styles and theories, some are still lacking thorough practical research.

Due to the variety in leadership literature, the concept of leadership goes by many definitions. More traditional literature often associates leadership with terms such as *Power, Authority, Management, Administration, Control,* and S*upervision* (Yukl, 2012). These terms feed into the idea that traditional leadership is focused on managers and hierarchy as a means of organising. Modern literature poses that leaders no longer

depend on hierarchical aspects to influence subordinates but focus on the creation of meaning (Alvesson, Blom & Sveningsson, 2016; Yukl, 2012). Modern leadership is therefore associated with terms such as *Authenticity, values, self-awareness, and group dynamics* (Marturano & Gosling, 2008). Kouznes and Posner (2023) describe that leaders create meaning through five practices, *The Five Practices of Exemplary Leadership*. According to them, a leader creates meaning through clarifying values, inspiring a shared vision, challenging the current process, enabling others to act without providing the answer and encouraging the heart of individuals (Kouzes & Posner, 2023).

Leadership theories refer to how and why certain individuals can become leaders, whereas the leadership style falls under certain theories, but refers to how they imply their power (Bass & Bass, 2009; Burns, 1978). Since leadership style is a hot topic, the amount of research has increased significantly, leading to a bunch of styles and theories with relatively small differences between them (Kessler, 2021). One such research on leadership in the book *Primal Leadership* by Goleman, Boyatzis and Mckee (2009) focuses on six emotional leadership styles which have been 'discovered'. These six styles are: "the visionary leader (emphasis on empathy), the coaching leader (connect organisational goals with the goals of individuals), the affiliative leader (emotional needs over work needs), the democratic leader (commitment of employees via participation), the pace-setting leader (challenges and sets goals for employees), the commanding leader (uses authority to give directions to employees)" (Goleman et al., 2009, cited in Vasilescu, 2019, p. 49).

Leadership and management are commonly used interchangeably in the workplace, leading to confusion (Kotterman, 2006; Marturano & Gosling, 2008). This confusion logically occurs because of the similarities the terms share with vertical modes of organising alongside power. Vertical modes or organising often refer to hierarchical elements associated with management (Alvesson, Blom & Sveningsson, 2016). Additionally, both terms often refer to problem solvers (Marturano & Gosling, 2008). Despite their similarities', modern academic literature differentiates them (Alvesson, Blom & Sveningsson, 2016; Kotterman, 2006; Kouzes & Posner, 2023; Marturano & Gosling, 2008; Nayar, 2013; Yukl, 2012). Managers are more associated with traditional literature on leadership. This is because of its goal orientation, focusing on counting values within its circle of power (Nayar, 2013). The focus on performance allows for a rational degree of order in which uncertainty and confusion are reduced. Additionally, motivation and creativity for peak performance to occur are limited (Alvesson, Blom & Sveningsson, 2016). As stated earlier, leaders focus on positive forms of influence through the creation of meaning, ideas, beliefs and values (Alvesson, Blom &

Sveningsson, 2016; Kouzes & Posner, 2023; Nayar, 2013). Unfortunately, the influential process often proves time-consuming due to unclarity regarding tasks and high dependency on individual skills (Alvesson, Blom & Sveningsson, 2016). Despite being interchanged often, what differentiates these terms the most is followership. A leader is nothing without followers (Alvesson, Blom & Sveningsson, 2016).

"He who thinks he leads, but has no followers, is only taking a walk."
As spoken by John C. Maxwell.

The role of the follower includes strong elements of choice, voluntarily placing themself in this role when confronted with leadership (Alvesson, Blom & Sveningsson, 2016). Only then a relationship of influence can exist. Thus far, Leadership and management have been discussed separately. However, it is not uncommon for managers to be leaders at the same time (Marturano & Gosling, 2008; Sveningsson & Alvesson, 2016; Yukl, 2012). The phenomenon of managers as leaders is often seen within organisations but might prove difficult. Where the leader wants to develop the organisation and set new goals, the manager's purposes are more narrow and focused on maintaining (Kotterman, 2006). Therefore, the creation of a leadership- and management style that complement one another, alongside benefitting the organisation and its staff, might prove difficult. However, leaders are in return also affected by the organisation and their followers (Alvesson, Blom & Sveningsson, 2016; Gottfredson & Aguinis, 2017; Yukl, 2012). Organisational effects on leadership might come from the constraints of top executives or environmental uncertainty and crisis (Yukl, 2012). Followers affect leadership behaviour through identity works (Gottfredson & Aguinis, 2017). Identity work is a constant change of one's identity to create a coherent view (Alvesson, Blom & Sveningsson, 2016). Therefore, the follower-leader relationship highly depends on a coherent identity view, for only then behavioural influences can occur (Gottfredson & Aguinis, 2017).

As may be deducted from above, leadership can be portrayed in a variety of ways, which all are highly sensitive to the given context. Different contexts require different forms of leadership as best practices. Therefore, this research continues by analysing forms of leadership in the healthcare sector.

Leadership in the healthcare sector

In the healthcare sector, a variety of types of leaders can be found such as nurse-, medical-, board-, team-, and organisational leaders (West et al., 2015). Despite this variety, or maybe because of this variety, the terms leader and manager are commonly

used interchangeably in this sector as well (Ayeleke et al., 2018). Another reason for the confusion surrounding these terms could be found in the healthcare history. Similarly to the literature, the healthcare sector is its origin highly hierarchical and bureaucratic (Dye, 2017). Therefore, the healthcare sector is strongly associated with transactional leadership, which emphasises respect for rules and traditions through legitimate power (Madsen, 2001). Additionally, to the leadership styles discussed above, transactional leadership is one of such styles. TL aims to motivate followers through exchanges of rewards and motivation by appealing to self-interest if this is relevant to getting their work done. (Alvesson, Blom & Sveningsson, 2016; Madsen, 2001; Yukl, 2012). Values such as honesty, fairness, responsibility and reciprocity are relevant to the exchange processes of TL, referring to the reward system (Yukl, 2012). A transactional leader's foremost task is therefore recognising followers' wants in terms of work and seeking for them to achieve this. In return for providing such achievements, an exchange of rewards in work effort is expected (Alvesson, Blom & Sveningsson, 2016).

As wants have changed throughout the years, so did the healthcare sector. The healthcare sector has been constantly reformed aiming at efficient, effective and high-quality delivery of patient care (Dye, 2017). Additional changes have been made to find solutions to challenges such as The increase in population and chronic diseases (World Health Organization, 2021; Wu & Green, 2000), Cost increases of medicine (Vincent Rajkumar, 2020), and Higher expectations of healthcare (Dye, 2017). To find solutions to these challenges, effective leadership in the healthcare sector is required (Dye, 2017). Effective leadership requires openness, conscientiousness, extraversion, agreeableness and neuroticism, to extend the performance of the team or organisation in attaining its goals. (Dye, 2017; Yukl, 2012). Relational leadership is a key aspect within the healthcare sector because relational leadership styles can affect the effects staff's well-being causing higher levels of mortality rates and medication (West et al., 2015; Wong, Cummings & Ducharme, 2013). Therefore, it may be concluded that academic literature views good relational leaders as effective leadership in the healthcare sector.

However, changes in the healthcare sector throughout the year also brought challenges, as current trends and workforce shifts caused conflict that derail decision flows and disrupt patient services (Dye, 2017). For example, the increasing involvement of clinicians in the planning, management and organisation of care has heavily affected the social context of the healthcare sector (Ayeleke et al., 2018). The developments above are making leadership more important than ever relying heavily on the passing on and development of cognitive skills among healthcare employees (Grohar-Murray, DiCroce & Langan, 2016). Leadership is thus changing its focus towards identifying and assessing

essential competencies of leadership that lead to more effective performances (Ayeleke et al., 2018). This development leads to the belief that the healthcare sector is straying further from the TL and moving more towards alternative dimensions of leadership.

Transformational Leadership

As major changes and involvement in decision-making take a heavy toll on the healthcare staff, TMM addresses that leadership plays an important role in the realisation of these phenomena. The pillar of 'Transformational leadership' focuses on the demand for relationships with co-workers and leaders from the healthcare staff.

Since the 1980s, symbolic dimensions of leadership have been developing moving beyond human and task-oriented challenges to the human dimensions of organisations (Alvesson, Blom & Sveningsson, 2016; Aslamazishvili, Ignatova & Smirnaya, 2020). The human dimensions work as countering tools for negative work-related attitudes such as low job satisfaction, ineffective commitment, and negative job involvement (Pfeffer, 2010). Therefore, symbolism started focussing on the creation of meaning, values and identifications, as people bring these aspects along with them, creating the elements of organisational reality (Alvesson, Blom & Sveningsson, 2016; Aslamazishvili, Ignatova & Smirnaya, 2020). Symbolism brought forth two particularly salient approaches to realise these symbolic dimensions of leadership. Namely, charismatic leadership and transformational leadership (Alvesson, Blom & Sveningsson, 2016). The course of charismatic leadership consists of four elements: The conditions of arrival (distress), the requirement for maintenance (mission success), the likely outcome (institutionalisation), and the exercise of authority (power and skills) (Conger & Kanungo, 1998; Willner, 1984). Charismatic leadership is referred to as a form of authority based on the perceptions of an individual (Conger & Kanungo, 1998). The leader creates this perception by formulating an appealing vision through strong communication, in which risk-taking, symbolic language and rhetorical skills are all presented in charismatic ways (Conger & Kanungo, 1987). Unfortunately, charismatic leadership is also sensitive to extreme narcissism and cannot desire or focus on structuring roles and responsibilities due to its dependency (Conger & Kanungo, 1998). The second approach, TL, relates to charismatic leadership in a broader way (Alvesson, Blom & Sveningsson, 2016).

TL goes beyond the perception and influence of an individual, by binding them together to realise organisational culture changes (Grohar-Murray, DiCroce & Langan, 2016). Burns (1978) proposed two kinds of leadership: transactional- and transformational leadership. As stated earlier, transactional leadership focuses more on the instrumental exchange by an individual (Burns, 1978; Grohar-Murray, DiCroce & Langan, 2016).

Whereas transformational leadership is a relatively new concept focussing more on the human dimensions by providing higher meaning and strong emotions (Kotter, 1982). Transformational leadership can therefore be defined as a relational leadership style of similar purpose between leader and follower based on inspiration, emotions, loyalty, and a strong commitment to empowering all employees with timely support to avoid errors and realise cultural changes through binding and influencing individuals (Alvesson, Blom & Sveningsson, 2016; Grohar-Murray, DiCroce & Langan, 2016).

Therefore, a transformational leader is expected to portray characteristics such as honesty, supportiveness, cooperativeness, and inspiration (Grohar-Murray, DiCroce & Langan, 2016). These characteristics are portrayed to realise idealised influence through stimulating intellectuality, motivation, and individualised consideration (Bass & Avolio, 2000). By this a transformational leader can conduct the five key actions of leadership: modelling the way, inspiring through a shared vision, challenging the process, enabling others to act, and encouraging the heart (Simpson, 2007).

However, TL is not easily obtained in practice (Spector, 2014). TL in practice shows factors that hinder performance as well, such as distance to employees and limitations of influence (Kerr & Jermier, 1978). Additionally, the diversity of needs and characteristics among employees makes TL challenging in practice (Bolden et al., 2012). Thus, TL can be interpreted as a visionary leadership style, implying great possibilities for increased well-being and performance, but remains relatively undiscovered in practice.

2.4. Summary Literature review

The literature presented above aims to guide the reader through the extensive number of elements that come to play during this research. Firstly, change and the impact this can have been emphasised, followed by how sense making in a closed system, like the health sector, could minimize the impact of change. From here the health sector and its complex systems are briefly discussed and it becomes clear that because of these, changes in this sector are mostly prone to failure. To create a more open system, the reader is introduced to the concept of governance, a network way of steering an organisation. This concept has been developed into shared and more recently the professional type of governance. Both these types are invented to create the open decision-making environment the health sector was searching for. To facilitate this new form of decision-making, leadership will play a major role. Managers who are currently seen as leaders at SUS will have to adapt their leadership styles. This transition is not entirely new as the leadership in the healthcare sector is by origin very hierarchical. However, in the last few years, this has become less apparent already. Because professional governance emphasises individuals being their leaders, the current leaders will have to adopt a leadership style that allows individuals to flourish. Providing these necessary needs and guiding individuals to be their leaders are elements often found in TL.

3. Methods

The design of this paper included a variety of philosophical and methodological issues for this examination to be carried out as successfully as possible. This chapter discusses how this research's philosophical foundations led to research that is based on interpretivism. This chapter will also describe this paper's abductive research strategy, which involved circling back and forth between the literature and the empirical data. This section concludes with an outline of the research methodologies used to perform this paper's analysis and the considerations that were made about source criticism, and reflexivity.

3.1. Choices and approach

Whenever someone reacts with a feeling of interest which makes them question all of their previous experiences, that is a clue that something that makes previous knowledge seem inadequate is found (Weick, 1989). The research aims to provide a representative view of the challenges and needs experienced by employees in the healthcare sector and analyse if the presented change model will resolve these.

More specifically, this research aims to discover the healthcare staff's views of leadership from the unexplored perspectives of nurses and what is necessary to realise the healthcare revolution of Sweden. The emphasis lies with leadership in the healthcare sector, for their role as leaders will be drastically impacted by the change to TL.
To realise this research objective, preference was given to a qualitative case study. The choice was given to a qualitative over a quantitative study because the day-to-day work for this research is to explain a competing perspective in social phenomenon and academic literature aligning more with qualitative research (Styhre, 2013).

The search for a concept rather than abstract data in an empirical study is what makes it interesting (Weick, 1989; Yin, 2011). The inductive approach aims to clarify or falsify existing theories through data, whereas the deductive approach is based on a hypothesis and deducts according to such (Locke, 2007; Yin, 2011). Abductive research combines the inductive and deductive approaches by challenging conventional thinking through empirical data investigation. After which changes or addition to the current academic literature are made (Alvesson & Kärreman, 2007). This research aims to contribute to current academic literature by describing the healthcare staff's interpretation of the practical needs of leadership in the healthcare sector and how the implementation of a broad systemic change model upholds in a professional context as a hospital. Therefore,

an abductive approach was adopted. The interpretive rule of TL was compared to the empirical findings, to form an imaginative articulation of a new interpretive rule (Alvesson & Kärreman, 2007).

The empirical data was collected through semi-structured interviews and document analysis. After this, the empirical data was analysed and interpreted to form empirical findings. Therefore, the research design can be categorised as descriptive (Yin, 2011). Firstly, the choice of conducting a document analysis of TMM based on documentation provided by SUS was made. The data-analysis allowed for examination and interpretation of TL and managerialism. This led to the creation of understanding and empirical knowledge (Corbin & Strauss, 2008).

In social sciences, nothing speaks for itself, but everything relies on interpretation (Denzin, 1994). Therefore, preliminary interviews were conducted, to create a better understanding of the broad systemic change model. All interviews were conducted in a semi-structured format as these allow for the exploration of deeply personal and sensitive issues (De Jonckheere & Vaughn, 2019). In this case, the response of the healthcare staff to the implementation of the change programme focusing on leadership. Given the shortage of academic literature on TMM in practice, interviews were conducted with proponents and experts of the included leadership style. The proponents consisted of managers who are currently or will shortly be involved in the implementation process, as this research aims to find different managerial needs for leadership in structural empowerment. Additionally, the experts were selected because where theory and practice often a gap, experts provide an ephemeral narrative more difficult to find in proponents (Finch, 2018; Van der Burg, 2008). Alongside already existing literature, the semi-structured interview allowed for empirical findings and interpretations that led to the adaptation of and challenges in current this literature.

Philosophical grounding

The worldview a researcher adopts is of importance, as it influences the chosen research method needed for providing reliable evidence for the topic of interest (Brown, 2009). Throughout the research, researchers have to maintain this set of beliefs as it guides their actions, also known as a philosophical worldview (Petersen & Gencel, 2013). Following the philosophical traditions, this research adopted an interpretive tradition. This adaptation helps to discover the managerial needs required for realising this theoretical transformational leadership style in practice. The interpretive tradition sees 'reality' as socially constructed through acts of interpretation, implying that there is no objective or factual 'truth', but only truth inherent in action (Prasad, 2017; Schwandt,

2001). This research follows the same line of thought, where the 'truth' is to be found but only after interviews have been conducted and experts consulted. Therefore, the interpretive tradition contrasts with the historical positivist view.

Whereas the positivist view sees reality as independent from the context but more as something that can be objectified, measured, and fixed (Alvermann & Mallozzi, 2010). The interpretive tradition sees reality as a sensemaking process of the context (Schwandt, 2001). Through the adaptation of the interpretive approach, this research acknowledges the healthcare staff's needs as a social construction influencing multiple hierarchical levels. Important to state is that the description of needs is highly context-dependent, relying heavily on the sensemaking of the researchers. However, according to Prasad (2017), insights of socially structured realities and knowledge can only be understood through interpretation.

Additionally, the research is inspired by an interpretive tradition variant. Namely, the symbolic interactionism tradition. Symbolic interactionism assumes every individual holds and attaches different meanings to social situations. The social structures hold up a mirror for individuals allowing them to reflect on their interpretations of the world and evaluate their role within the social structure (Prasad, 2017). For this research the social structure regards the interpretation of TL and what this means for the professional context of the hospital.

The homogeneity of traditions in research may be less than perfect or precise. Multiple traditions tend to be adopted and overlap in one research (Jacob, 1989). This research adopted the interpretive traditions because of the philosophical issues related to ontology and epistemology. Ontology and epistemology refer to the nature of reality and knowledge (Al-Ababneh, 2020). The philosophical issue was the lack of academic literature on the nurse's perspective on leadership when changing, leading to the inclusion of elements of the critical tradition. As the critical tradition allows for a more sceptical view of TL than the interpretive tradition (Prasad, 2017). The adopted elements of the critical tradition go beyond critical thinking, systematic reflection, and criticism, but aim to critique and change (Alvesson & Deetz, 2000; Prasad, 2017; Prasad & Caproni, 1997). This additional philosophical view created a better understanding of the differences in academic literature and practice.

Lastly, certain research approaches and traditions as above can often confuse the reader. To avoid any confusion, a clear description of the project is of the essence. Therefore, a writing style is necessary to give the reader deep nuance of the research

approach. Styhre (2013) argues that academic writing is a professional skill requiring lots of practice. However, to contrast a nuanced writing style defining precise technical terms, metaphors can be adopted. Schaefer (In press) states that metaphors are creative tools to make sense of difficult to grasp phenomena. Based on this philosophy, this paper adopted its metaphors.

3.2. Data collection

To get the most applicable results for the aims listed above, two different methods were used, interviews and document analyses. Please find a visualization of the research design below in Figure 6. For the interviews, different samples were taken, both from within and outside the organisation. This using of different data collection methods also augments the credibility through the use of data triangulation (Noble & Heale, 2019). In the following chapters, a justification of the data collection methods is given.

<table>
<tr><td colspan="2">Problem Framing
Document analysis – Defining the research question</td></tr>
<tr><td colspan="2">Desk research
Literature review</td></tr>
<tr><td colspan="2">Primary Quantitative Research</td></tr>
<tr><td>Interviews</td><td>Expert Opinions</td></tr>
<tr><td colspan="2">Empirical findings
Literature review – document analysis – Interviews – Expert Opinions</td></tr>
<tr><td colspan="2">Discussion
Suggestion for further research</td></tr>
</table>

Figure 6: Research Design

Sampling details

For this research, the population of the primary research was determined to be the managers with nursing backgrounds, directly involved in the implementation of the new

changes at SUS. Out of the 38 managers, 8 were interviewed, all varying in age and working experience. This allowed the researchers to broaden their scope on the topics presented. To ensure that the most relevant knowledge would be gained from the interviews, the researchers contacted the hospital to set up the interviews. This allows for non-probability sampling (Aken et al., 2012), which limits the researcher in terms of gaining an explorative broad view of the matter, but allows the researchers to identify the main areas of interest. Since the interviews were set up and predetermined by the hospital staff, a form of convenience sampling occurred. This form of sampling is also known as accidental sampling, which is a form of non-probability sampling where interviewees have certain practical criteria e.g., easy accessibility or availability (Etikan, 2016). Next to interviewing managers, experts in the field were also examined, these interviews allowed for a critical view of the findings presented, thus creating a data triangulation (Aken et al., 2012). During all the interviews anonymity of the participants was assured, and the researchers opted to create pseudo-names. Please find a table with the names below in Figure 7. Alvesson and Sköldberg (2009) state that assuring the interviewee of an anonymous interview will increase the chances of receiving honest and more in-depth answers. This adds to the phenomena described by Alvesson and Sköldberg (2009) which says that external researchers gain more honest answers. After stating the above, the interviewees were asked for permission to record the interviews. All the above is in line with the confidentiality agreement signed between the researchers and SUS.

Interviews

As stated in Chapter 3.1., semi-constructed interviews were chosen over observations, since an interpretive stance was chosen. Since both in depth interviews and observations are useful to gain a comprehensive understanding of individuals only interviews were chosen (Goodwin & Horowitz, 2002). According to Kvale and Brinkmann (2009), when coming up with interviews in qualitative abductive researchers follows the following 7 steps; 1) identifying themes, where the analyst describes what to do as well as how and why, 2) planning, 3) interviews, 4) transcribing, 5) analysis, 6) verification and 7) reporting. This approach is also chosen for the preparation of the interviews in this research. Herein the first step is centred around establishing themes that become apparent in the literature presented. In the planning step, the researchers should take these themes and create an interview strategy (Plas & Kvale, 1996). Kvale and Plas (1996) describe these strategies as metaphors from the interviewers' perspective to make clear what role he plays. These metaphors are described as the miner- (actively searching for answers) and traveller- (wanders around in search for answers) metaphors (Plas & Kvale, 1996). This is further elaborated by Buetow (2013), who continues by

saying that taking a role as an interviewer makes it clear what one wants to research. To better the flow of interviews, researchers can also form their roles (Buetow, 2013; Plas & Kvale, 1996). This idea was continued in this research, where it opted to create a metaphor to make the interviews run smoothly. The researchers wanted to continue the abductive research structure in the interviews. The idea of abductive research reminded the researchers of the forming of a stalagmite and stalactite into a solid pillar. Since with each droplet of value, information gathers from the interviewee (stalagmite), the interviewer's (stalactite) knowledge continues to grow into ideally a solid pillar at the end of the interview. This interview approach formed around the three elements that were deemed most important from the literature analysed. Herein the researchers asked descriptive questions with an explorative nature to find out together what the phenomena entailed (Aken et al., 2012; Plas & Kvale, 1996). The questions are designed to be descriptive to find out what the main elements of the literature review entail according to the participants (Rennstam & Wästerfors, 2018). As stated by Kvale (1995, cited in Rennstam & Wästerfors, 2018) "what and how" questions were preferred over why questions as these allowed for a more dynamic interview, more suited for follow-up questions.

To set the scene for the interviews, since some managers were not confident speaking English, an "interpersonal relationship" at the beginning of the interview was created, mostly consisting of some jokes or the interviewers making fun of one another (Kvale & Brinkmann, 2009).

As a second data collection method, experts in the field were also interviewed to gain a more interesting discussion (Aken et al., 2012), next to the managers interviewed. Three interviews were conducted, all focussed on the same expert field, but with other traits and specialities. This approach allowed for a broad view of opinions to be gained (data triangulation) (Aken et al., 2012; Noble & Heale, 2019). The experts were chosen as their field of interest was in; experience, management/leadership theory and management work experience, respectively. The expert interviews were made in a semi-structured format, with asking interpretive questions which, according to Kvale (1995, cited in Rennstam & Wästerfors, 2018), allows for a common in-depth view on the matter. These questions are mostly used when an understanding of the matter has already been established.

The table below lists the fifteen people, the synonyms of their names, gender, and their role (according to them) (see Figure 7). As Chapter 4 will discuss the empirical data provided by the fifteen people listed below, this table aims to provide a reference for

each of them. To maintain confidentiality and anonymity, the names of the interviewees were changed to common Swedish names.

	Synonyms name	**Gender**	**Role**
1	Astrid	Female	Manager
2	Ebba	Female	Nurse
3	Alice	Female	Professor/Ex board member nurse association
4	Emma	Female	Lead nurse
5	Elsa	Female	Lead nurse
6	Agnes	Female	Head of department
7	Maja	Female	Head of operations
8	Olivia	Female	Change leader
9	Linnea	Female	Change leader
10	Annika	Female	Change leader
11	Tova	Female	Support manager
12	Alexander	Male	Professor in Business Administration
13	Sara	Female	Manager
14	Alex	Female	Anaesthesia nurse
15	Britney	Female	Nurse operator

Figure 7: Anonymous list of interviewees

Document analysis

Thirdly, to ensure a proper understanding of the scope of the research, documents were sent to the researchers by the hospital. These consisted of the way the hospital operated, information on the implementation of TMM and gaps analysed. These preliminary documents were analysed and allowed for better interpretation and understanding, aiding the research in the start-up phase (Corbin & Strauss, 2008).

Combining the three methods of data collection allows for data triangulation, which helped to create a better picture of what the data presented was saying (Saunders, Lewis & Thornhill, 2012). These documents remained classified to ensure the confidentiality agreement between SUS and the researchers.

3.3. Data analysis

This research used several data analysis tools. Firstly, document analysis was conducted. Document analysis can be carried out as a stand-alone study or as a part of a broader qualitative or mixed methods study (Gross, 2018). In the latter case, which was apparent in this research, it is frequently used to triangulate findings obtained from another data source. (e.g., interview or focus group transcripts, observation, surveys). According to Gross (2018), documents can support or contradict, clarify, or add to results from other data sources when they are used in triangulation, which helps prevent bias. The document analysis was conducted in a thematic way, where patterns were found (Bowen, 2009). This allowed the researchers to come up with a thorough research question.

Next to the documents, the semi-structured interviews were also analysed. After interviews were conducted, the researchers had to transcribe these, therefore a tool was used. However, to ensure reliability, the researchers listened in to the tool as well (Saunders, Lewis & Thornhill, 2012). From there, an explorative data analysis method was chosen. The document analysis allowed for the RQ to be formed from which a structure was created, as can be seen in Figure 6 Research design. This structure was necessary because without one, something cannot be explored (Chatfield, 1986). While analysing if what is discovered is relevant for the research, the underlying assumption should be around the knowledge of data, as this allows for effective development and testing of refined theories (Hartwig & Dearing, 1979). Hartwig and Dearing (1979) continue by saying that this approach aims to maximise what is learned from the data, however, this requires adherence to two principles: openness and scepticism. Taking these terms in mind when analysing the data, one should be open to unanticipated patterns, while also being sceptical of the data found and how it is summarized (Hartwig and Dearing, 1979). The researchers considered this, as the interviews were colour coded on reoccurring themes identified by the researchers. After each interview, a critical look was given at the transcript which resulted in a slight adjustment of the colour codes, until eventually, the following themes were identified to be explored more in-depth in the next chapter.

The colour codes:

1. **The view of the model**
2. **The effect of the model**
3. **The need for new leadership**

Once the colour codes were established, patterns could be found, this step is called to data manipulation phase (Stebbins, 2008). Herein, the transcripts are closely examined, with an eye on discovering their common traits, which will be mended into generalizations for the new theory. Forming these reoccurring themes into a new concept is at the heart of discovery research (Stebbins, 2008). According to Glaser et al. (2010), once these reoccurring themes were identified, the analytical phase starts. Herein, the descriptive concepts are shaped into codes which can be used for the empirical findings chapter. These concepts can be used to build on the existing literature found to discover new phenomena (Glaser & Strauss, 2010). Following an analytical approach in the last two chapters, findings are presented and analysed next to the literature found in this research.

3.4. Credibility, reliability, validity, and limitations

As qualitative studies are sensitive to a variety of challenges, this chapter aims to ensure the trustworthiness and credibility by addressing the research's limitations. By discussing all procedures and limitations of the research transparency is created, and only through this transparency a research is able to withstand scrutiny by others (Yardley, 2007; Yin, 2011).

Firstly, this paper addresses the choice of a single case study. Johnson and Christensen (2014) state that a single research study can never be treated as a final word of a topic. Furthermore, Yin (1994) argues that to generalise at least three cases need to be studied, five or more when dealing with complex phenomena. Therefore, this research cannot make any generalisations on the empirical findings regarding TL in a professional context such as a hospital. However, a single case study does provide value for group

research, such as the pedagogical analysis of how TMM might resolve challenges within the healthcare sector (Barker et al., 2011). Additionally, the study allows for replication by other researchers to create a more confident outcome that could lead to the creation of a general concept (Johnson & Christensen, 2014; Yin, 1994).

Due to the sensitive nature of personal information in hospitals, the researchers were not able to contact the interviewees directly. Therefore, contacting the interviewees became a time-consuming process in which the capacity of transferable knowledge was minimised due to the indirect communication channel (Hartmann & Dorée, 2014). When the interviews were conducted a language barrier occurred. Although both parties were sufficient in the English language, neither of the parties are native speakers. This led to difficulties in sharing knowledge and creating an understanding. As the relationship between the interviewee (knowledge sender) and the interviewer (knowledge receiver) became arduous due to potential information getting lost in translation errors (Hislop, Bosua & Helms, 2018; Szulanski, Ringov & Jensen, 2016). As a language barrier might impact the reliability of research, the translation errors were kept minimal. The similarities between the Dutch and Swedish languages played a major part in this. When a party found difficulty with the right phrasing, phrasing it in their native language often proved sufficient to create an understanding. Looking for the right words and phrases became a returning humorous process throughout the interviews. When this did not, the recording of the interview allowed for translations in the post-editing process. Through these actions, the reliability was maintained. However, although the challenges of the language barrier were limited, a native Swedish speaker might have found different findings due to a lack of translations (Alonso, 2017). Additionally, it is important to state that throughout eleven interviews a total of fifteen people were interviewed. The reasoning behind this is that some respondents felt more comfortable answering questions in pairs. Because the views of the interviewer might affect potential outcomes (Harris & Fink, 1987), the choice was made to allow this request.

Therefore, to maintain the credibility of this paper, multiple sources of data were used. The process of using multiple sources of data to cross-check empirical findings is called triangulation (Bell, Bryman & Harley, 2019). The multiple sources of data were made up of semi-structured interviews with experts and proponents of TL to generate a diverse perspective. By considering multiple perspectives, this research gathered a diversity of empirical data. This allowed for a more accurate interpretation of the needs of healthcare staff. To increase the trustworthiness of this paper, only experts involved in the implementation process were interviewed. Additionally, a document analysis allowed a contrast to be created between this research's empirical findings and the academic

literature. This paper argues that only through different perspectives and comparisons, a trustworthy contribution to academic literature can be made. To increase credibility further, the researchers opted for source criticism by only trying to read primary data sources. However, on some occasions in this report, secondary data was used, reducing credibility.

Finally, this research only lasted a short period consisting of a document analysis and eleven interviews existing of fifteen participants. Therefore, a more depth qualitative single might provide a different conclusion than this paper. However, all limitations and biases are considered. This paper aims for trustworthiness through constant reflection on the research and providing the reader with a transparent view of the work process. This paper ensures the conclusion and the findings on which it is based, have been made as unbiased as possible. Overall leading to a paper that is as credible and trustworthy as the researchers could provide.

4. Empirical findings

The following chapter will present this paper's main themes with additional sub-themes. These themes came to light through analysis of the empirical material, following the narrative of comparing TMM to the needs of healthcare staff. All the following themes were derived from the interviews, both with experts and employees at SUS. Following the line of thought from Weick (1995) on sensemaking, this chapter aimed to see how employees made sense of different concepts from the model. The first theme showcases how TMM is interpreted by the employees at SUS. This theme provides a view of the positive, negative, and prejudiced interpretations of TMM. The second theme discusses the challenges TMM aims to resolve and the challenges experienced by the employees at SUS. The last theme focuses on the needs of leadership by the SUS employees. Here empirical material is presented that shows how healthcare staff portrays leaders, what characteristics are looked for in a leader, and how these fit in TMM. After discussing the empirical findings, a summary of the key findings will be presented.

4.1. The View of TMM

With the healthcare sector facing a variety of challenges, resolutions are sought in restructuring. Britney revealed, the kind of patients SUS has today, requires a heavier workload. The changing workload of patients possess the biggest challenge and the way these challenges are addressed have been changing as expressed by Maja:

"*The biggest challenge now is to elevate the difficulties as to meeting an increased need for the care of the aging population* […] *and the way to meet these kinds of problems have changed over the years.*"

-Maja

Interestingly, whilst conducting the interviews, all healthcare staff was aware of the difficulties SUS is facing right now. All staff members seemed to share concerns regarding the patient's health. As the hospital is a place where patients want to get a sensation of security and safety, the nursing staff expressed the importance of being able to spend time with patients and routinely work with the same patients. But as Head of Operations Maja expressed, the way these problems are met has changed over the years. And with these changes, the way change is looked upon has differed with it. Ebba builds forth on this by expressing that change is a continuous process that simply cannot

spontaneously stop and start again. "*Then it (change) has to be ongoing […] it cannot just lead with twists.*" Sara shared this idea of change as a continuous process and added to it by expressing the difficulties of time sensitivity during change processes.

"*(Change) is like a hanger ship. It starts in the direction, if you want to turn, you have to start about five years before your shift your angle at all. Everything goes so slowly.*"

-Sara

A level of inertia can be deducted from Sara her take on change, as change is believed to be a straightforward task until external factors derail its course. Based on the above, changing towards a new way of working has become adequate. As the change process can be seen as slow and straightforward without major adjustments, other respondents view the structural changes as fast-paced solutions. Interestingly, the views on TMM as such a new structure have proven to divide the healthcare staff at SUS into proponents, adversaries, and prejudiced.

Positive views on TMM

The following subtheme, *positive views on TMM*, focuses on the exploration of data regarding TMM as portrayed by the respondents. Hereby, the exploration focuses on the interpretation of positive views stated by respondents during the semi-structured interviews.

Throughout the interviews, many interviewees provided us with examples of (previous) situations where change is necessary to increase the efficiency of patient care. Where commonly salary is viewed as one of the necessary changes to occur in the healthcare sector, healthcare staff views this differently.

"*Every nurse should have so much more salary, but I think you need that if you do not like your job. […] if you feel that you like to go to your job, then then you do not think that you need more and more money every day.*"

-Agnes

This statement emphasizes that finances are outweighed by job satisfaction, which is interpreted as reachable through core tasks. Agnes and her colleagues shared similar ideas on the importance of job satisfaction and motivation, as administrative tasks have driven the workforce further from what they perceived as their core values. The nurses

especially stated the importance of patient care, and that job satisfaction outweighs their need for salary increases. Alex is one of these employees saying:

"There are a lot of other administration personnel, instead of personnel working with the patients. We (Nurses) have less time with the patients and more time with the documentary and different computer system without taking care of the patients. […] We (SUS) need more colleagues the big issue for us (Nurses) is to sit here. And we know that we need to be out there working. But instead of that we are doing this. (Administrative work)."

-Alex

Here, Alex further emphasises the need for a decrease in administrative tasks. A sense of frustration was picked up during the interview as the current working situation leaves healthcare staff believing they are not actively contributing to patient care. Because of this frustration with core tasks, employees are convincing higher-ups to allow staff to focus on their main tasks. Given that the administrative work is portrayed by healthcare staff as time-consuming and only adds more work to the original workload. Alice expressed critically that "*I do not think that nurses should do things that they do not need to do with nursing […] not too much administration.*" Moreover, Ebba believes that SUS should take the example of American hospitals that implemented TMM already.

"In America, it's the entire hospital that becomes accredited. And then it starts from the highest leadership positions. That is behind the transformation, and it goes through the whole system. Here we're trying to implement it on a very closed off and limited ward and I think that's going to be a problem."

-Ebba

Ebba and her colleagues often referred to American hospitals throughout the interviews. It became evident that they view magnet hospitals as organisations in which healthcare staff can focus on these core values, actively reducing the amount of administrative work. Given the spoken need for increased time for patient care, whilst lessening administrative tasks, the implementation of TMM (broad systemic change model) is seen as a positive resolution to current challenges.

As all respondents at SUS agreed that returning to the core of their profession is portrayed as a positive point from TMM. However, a tool like TMM simply does not resolve all challenges directly according to many of the respondents. They believe that the shift back to their profession can only be realized through structural changes at SUS.

Due to the increase in administrative tasks, it is found that many colleagues are less aware of what colleagues outside of their tube are working on. Elsa believes TMM will address this challenge positively:

"That's the positive with a magnet model, I think is the structure. I know exactly what you're going to do. And many of our nurses are just asking for that."
-Elsa

Interestingly, Elsa states that especially the nurses are asking for clarity and structural changes. This implies that Elsa believes the nurses are currently suffering the most from administrative tasks. Furthermore, the lack of an overview of operations in other wards seems to pose difficulties for the nursing staff as they are the ones transferring patients between tubes.

The difficulties of the current tube system are expressed by more respondents than Elsa. Other respondents believe a new structure is of the essence in which a new decision-making style is needed. This means that respondents believe the implementation of TMM will allow for changes in decision-making at SUS.

"Magnet, like shared governance is the decisions have to come from the personnel and up because they know, what needs to change."
-Agnes

Agnes provides a clear vision of what this new decision-making style should look like. It becomes abundant that Agnes believes the new structure should be bottom-up, as in bottom-up "*everybody on the bottom has a say"* according to Sara. Moreover, the professionals working on the floor are the most experienced and know where the needs for change are. Interestingly, this simultaneously implies the hierarchy at SUS is currently top-down, limiting the influence of decisions from the work floor. Sara believes the current hierarchy in place needs to be *"taken down"*. Allowing for the decisions to be made in the wards themselves. Regarding this, Jessica states the following:

"It's also a way to take the decisions that the wards decisions can actually be taken by the nurses."
-Jessica

When wards are allowed to take such decisions internally, wards can also communicate these successful changes with other wards, thus ensuring better communication. Linnea,

being one of the change leaders, stated that the model *"is more just sharing knowledge".* This is further elaborated in the following quote from the question: What will this model bring to the table?

"[…] that's why I think that we should have what we call shared governance...we should work evidence based on patient safety, and we should have continuous quality improvements and informatics and a team that needs to be in a transparent way that everyone knows what's going on, ensuring the open communication along the way."
–Alice

As becomes clear from the statement above, Alice believes shared governance provides a tool to ultimately ensure open communication, alongside additional improvements. This open communication refers to the breakdown of tubes, improving the collaboration amongst wards stuck in different tubes. Moreover, this implies that employees see the model more as a communication tool for processes that are lacking now. In the form of the proposed shared governance. Elaborated further by Sara, who mentions that *"shared governance is how you allocate the decision making on lots of people all the stakeholders or all the interested people"*. Uniquely, Sara expresses here that TMM, of which shared governance is a tool, results in the decision-making over all the interested people. Implying that not only all organisational members and stakeholders will be involved in the decision-making process but will also be affected by the decisions made. As decision-making involves lots of communication, some respondents addressed the potential knowledge exchange that occurs with the discussion of decisions.

"[…] And the shared governance there (in shared governance meeting), it's enabling to get new knowledge from other departments that we don't always have today."
–Annika

Remarkable is that Annika expresses the limitations of knowledge sharing amongst departments today. Not only is there a limited amount of decision-making, but the lack of sharing knowledge is also believed to be an unfortunate by-product of this.

Furthermore, Tova believes that the shared meetings are also to make decisions without managers. *"[...] Because I think that's one of the big changes due to the magnet model is the shared governance. That also means that you have the professionals, those who have knowledge about evidence, making the decisions."*

This quote is taken from Tova on how the meetings will influence the organisation. Additionally, this draws an interesting contrast between Tova's and Sara's interpretation of shared governance. Where Sara believes it allows for decision-making between all members at SUS, Tova describes it as decision-making without managers.

Tova mentions that shared governance makes decision-makers out of professionals in the form of these shared meetings. Because the professionals are the most experienced, Tova believes they should be able to make their own decisions without a manager. Taking shared governance one step further:

"[…] and going to the professional governance as that you will be able to take your decision as a professional, you will manage your decisions and you and the team are included in all the different professions that are in the team are responsible for their decisions, of course, as well."

-Tova

Tova states the necessity of moving beyond shared governance, to a tool that allows for individual decision-making without the necessity of a manager. Namely, professional governance. Tova explains this as another way of decision-making where not now the whole team of professionals is included to take decisions, while also being responsible for the outcome at the same time. When Maja was asked about this follow-up step, she said that professional governance is *"[…] a collaboration with the doctors, and for them to make decisions in their proper, professional area, and that we allowed them to do that, and we make conditions for them to do that."* Meaning that the professionals take decisions based on the environment created by the nurses. Moreover, Maja implies here a strong phenomenon of professionalism with nurses allowing doctors to be the decision-makers in their area of expertise, whilst also working closely together as colleagues (collegialism).

Currently, at SUS, there is not a lot of collaboration going on. Especially nurses expressed their concern with having a very individual profession. Additionally, Alex believes that this individualism makes it more difficult to efficiently operate with "*[…] the right thing at the right place with the right person.*" Although nurses at SUS expressed their love for decision-making, additional collegialism is welcomed a lot. Because SUS is a diverse organisation, the interviewees believe that collaboration between individuals, wards and departments will lead to improvements in problem-solving and generating new ideas. Alice continues by stating that collaboration between new and more experienced staff members will provide additional learning opportunities and increased

inclusiveness amongst staff members. This paper found that many of the interviewees related the need for collaboration with a decrease in hierarchy.

"*From my experience in the hospital world, there is a hierarchy within the professions of who are ranks, who decides over who knows more than who, and who gets to say the final word. And at the end, if we talk professions, then the doctors are on top of that hierarchy. And then within the doctors, they have their own hierarchy of the more educated you are. So, it is like a professional hierarchy of education.*"
-Ebba

This paper argues that Ebba describes a phenomenon within the hospital world, that leads to feelings of diversion and frustration amongst the healthcare staff. It appears that the hierarchy within SUS is highly top-down with almost no voice from the bottom going upwards, emphasising the phenomena of the tube systems as SUS. The limitation of communication by this vertical tube system results trust issues in other wards as they find it difficult to trust others when they remain unaware of their status.

"*We do not trust each other any longer. […] You know, your role and the colleagues know, their other roles, my feeling is that I can trust my colleagues that they know what I expect from them. […] The problem is that we don't trust people. We don't trust other people, then we go somewhere and check it up.*"
–Alex

Alex's statement on trust clearly shows the environment some staff members experience at SUS. Flattening the hierarchy is supported by many among the healthcare staff. Additionally, the creation of a forum or place to discuss issues allows for a sense of ownership within one's work whilst simultaneously improving the working environment. Ebba continues by stating "*If you're in an environment where you have your basic needs met, you feel secure, you feel trust, and you feel that you can develop, it's also easier to handle a stressful day.*" Therefore, ownership and discussing issues can positively affect the feeling of trust amongst healthcare staff. Moreover, many respondents stated that alongside trust, feeling more pride in their work would also be beneficial to a good work environment.

Thus, TMM is a welcomed phenomenon with Tova saying that "*then I don't have to ask four levels up for something and get them to agree".* These new forms of hierarchy allow for more responsibility amongst nurses, something they have been waiting for a long time according to Olivia. With these implementations: *"I think, personal governance and*

transformational leadership, if that were the functions, then then I think we have taken care of the basic needs for our nurses." Was an ending statement in the interview with Ebba, stating that the basic needs for nurses need to be addressed to function to the normal levels.

Critical views on TMM

As with any new introduction of a change, critics are always present. Below you will find a short narrative of critical views on TMM to be considered when implementing.

Analysing the empirical data, it becomes clear that the hospital operates differently amongst wards, units, and departments making it difficult to find similarities between them. Agnes confirms this by stating that leaders especially operate very differently within the hospital with some working more on the creation of a good environment, whereas others are goal orientated. Agnes further expresses that she sees the goal of the magnet operations but also emphasises differentiation. Thus, Agnes addressed the difficulty of implementing a broad systemic model, such as TMM, that aims to align work processes in an environment that is so diverse in its operations.

When looking at the decision process, the hierarchy is still a subject of debate. Ebba said that *"A lot of the decisions cannot be made on first-level bosses".* Here she refers to shared governance, which cracks down the hierarchal structure of the whole organisation, saying that some decisions are still too far-fetched for the rest of the organisation to have a say on. Sara emphasises this by saying: *"Some decisions might have to be done on the top, because you can't wait for 15,000 people to decide something. But I think yes, the more things that can be decided by us on the ward should be decided by us things that we are involved in and makes a very important part of our work."* Clearly stated here is the fact that not everyone always needs to have a say on matters, however, that the decisions for their ward should be kept to them as well, as the employees of the ward are the experts in this specific area and can therefore make the best decisions which strongly links to literature on professionalism. Thus, probably excluding strategic decisions made by higher-ups for the hospital.

The fact that some decisions cannot be made by everyone was a reoccurring theme, with many asking where the line should be drawn if everyone can have a say in things. *"They are so low in the rank, and then lots of things that happens higher up, we don't have the knowledge of, should we even be allowed to take other decisions?",* is one of these quotes from Sara on the matter of who needs to take the lead. Sara implies the essence

of professionalism once more here by stating that the lower personnel is not aware of the decisions made by the higher-ups and believes that reversing the decision-making process would leave lower personnel with decisions out of their expertise. Tova agrees by stating *"I think the hardest part will be for all professionals, professions, I mean, the physicians, as well as the nurses to use each other in a right way of decision making."* Since *"The tradition is still, that the physician's decision is more valued",* clearly saying that these decisions will be naturally made by the person with the most knowledge, the physicians. This is in line with *"Some people will probably take charge of that situation (shared governance) easily"* expressed by Alexander on this matter. Given that knowledge is viewed as one of the most valuable assets a professional can have in the healthcare sector, a request for the gathering of additional knowledge becomes apparent.

"I think they need more than education; I think they must live and maybe workshops that they must talk with other leaders? Yeah, I think education is a step for everything."
– Maja

Such changes will cause practical issues during the implementation process, Maja already voiced hers by saying that education is probably not enough to change the leaders around. Perhaps, letting them follow other leaders will open their eyes, Maja says. Emma also emphasises with the need for training for herself: *"So I need to put in quite a lot of leadership training"*. The goals must be clear, what is it that the board wants the managers to be? As can be understood from the following quote from Maja: *"Educate all these employees in why we do this, and what the goal is and the way to the goal?"* leadership does need to be trained, but 'how' remains the question.

In terms of the structural empowerment proposed, there are also some uncertainty elements present. Alexander says that *"For others most, I think, really, don't expect to do that. And I think that they feel, anxiety around this (shared governance), what does this mean?"* He is sceptical about the idea of shared leadership being introduced to people with no experience in this field. According to him the following scenario can happen: *"And so I hate, if they bring these nurses to leadership development, I'd hate to see if they read too much about all these mystified concepts around leadership and came back to their organisation and thought that they should be just spiritual or emotional, or authentic, and all that, and try to apply much of the stuff that they have been taught that at some resort, or whatever, during weekend or that, because that's going to clash with the reality of the hospital."* Alexander says that many of the people going to be involved in leadership will lose their authenticity by following classes on these ideas

around leadership, the more modern and mysterious approaches to leadership. Moreover, Alexander expresses the importance of thinking differently from the herd, and not just assuming the presented knowledge as the 'truth'. According to Alexander, the real development lies in thinking critically about the information that is presented.

"So, what we need are more critical thinking around leadership, that demystify the concept. So, I can make efforts in demystifying leadership. But you know, I fight against windmills like Don Quixote."

–Alexander

With this quote, Alexander aims to say that leadership and following is still a mysterious concept. And trying to clear this up, can be seen as a helpless cause. Further stating *"Much of this has been said before, there are many ways to this so there's lots of reinvention, of old substance in new packaging, especially in the leadership area."* It can be interpreted that creating new ways of leading or decision-making is mostly not much different from what has been done before. But like said before, it can still be a mysterious concept, with different challenges along the way. Ebba says that *"This will clash with the way we see leadership at SUS"* and Linnea voicing that because of this new model *"Some will feel threatened and feel that they are losing a part of their leadership."* Since this new way of leading or decision-making is mysterious as Alexander said, managers will feel threatened in their day-to-day operations and probably will have to change their leadership style or clash with the new reality.

All the empirical findings above show that TMM also receives more critical views on the often positively portrayed shared decision-making as it is believed not everyone is capable of doing this. Furthermore, decisions will often be made by the most knowledgeable, sparking a big interest in education. However, this education might stop healthcare staff from thinking critically themselves and view presented knowledge as the 'truth'.

Prejudice

Alongside the positive and negative responses towards TMM, some interviewees voiced that they were unaware of certain concepts and changes proposed. This lack of clarity among some of the respondents left them with feelings of uncertainty and frustration. This sub-chapter focuses on exploring the empirical data of uncertainty and confusion regarding TMM.

Where many respondents expressed that they experienced levels of uncertainty when TMM was introduced to them, the preliminary interviews described the introduction of educational tools as workshops to take away certain uncertainty. The change coordinator expressed that education is of high importance when implementing new ways of working. However, from the interviews, it became clear that the provided education so far has not always been enough. Astrid expressed that her uncertainty about TMM led to a lot of questions as "*What will happen?*", "*Will I have time for this?*", and "*How will this affect me?*" It became evident that some of her colleagues who have been further involved in the education of TMM were able to answer these questions more easily. Although, amongst them, certain questions remained unanswered.

Alongside the lack of understanding amongst some of the staff at SUS, addressing the right challenges has also proven a topic of discussion. Sara is relatively positive regarding the model but also expresses some confusion as she well-described "*The elephant in the room, nobody is addressing it.*" Sara implies that certain challenges at SUS are currently unaddressed. Furthermore, the idea of changing the organisation through a tool to make it more attractive for the staff is viewed as something good. However, to change the right things, challenges need to be addressed, and currently, Sara believes the issues are not always addressed. Astrid expresses this confusion perfectly by stating the following: *"I don't know really what to say. Because I don't have the words, or the description clear for myself."*

As can be read, the views on TMM differ quite amongst SUS's healthcare staff. Overall a positive view can be found with staff members finally believing to have found a solution to the many challenges. However, more critical views are found regarding the capabilities of decision-making by lower personnel. The main reason for critique is the lack of knowledge to make decisions for higher-up levels as their knowledge on this is limited. A further need for education is highlighted by the prejudiced view, stating that some employees are still very unaware of what all this will entail and how this will work in practice.

4.2. Model versus the views from employees

In the previous chapter, positive and negative views from employees on what TMM could resolve were presented. In this chapter we will discuss the empirical findings from SUS's healthcare staff about TMM, these will be linked to the challenges presented in Chapter

1. After which, the views from the employees will be presented on what TMM will resolve (matches) and views from employees that are not aligned with TMM (mismatches).

Challenges	Views from employees at SUS
Bureaucracy	The current tube system relies heavily on top-down approaches limiting the healthcare staff in their profession.
Limited communication	The current structure limits the communication amongst colleagues creating a lack of an overview of operations in other wards, posing difficulties for the nursing staff
Less inclusivity	Although nurses at SUS expressed their love for decision-making, additional collegialism is welcomed a lot, which TMM will bring in the form of the shared governance.
Less focus on core activities	The increase of administrative work is seen as time consuming and adding to the already high workload, proving not beneficial to core tasks.
Declining motivation	The stray away from core tasks has led staff members to experience levels of demotivation as they are no longer working on what they perceive as patient care.
High staff turn-over	All views above combined together with the changing views and demographic of the workforce, the declining motivation has led to many employees changing course.

Figure 8: Views versus challenges

All respondents at SUS agreed that returning to the core of their profession is portrayed as a positive point from TMM.

Matches between views and the model

By analysing the empirical data, it has become adamant that the healthcare staff at SUS is experiencing similar challenges as the healthcare sector. TMM aims to resolve the most experienced healthcare challenges, which could explain why TMM is viewed positively by the employees at SUS. This sub-theme is going to address the matches between TMM and the view of the employees about resolving current challenges in the healthcare sector.

The healthcare staff expressed their need for structural changes clearly. The main aim of these changes is to realise professionalism by going back to core tasks. TMM focuses on returning professionalism to the healthcare staff in the form of Exemplary Professional Practice. Therefore, the employees interpret TMM as a way of returning to professionalism allowing them to focus on their core tasks. The healthcare staff at SUS describes these core tasks as everything that benefits patient care. This implies that tasks will shift from administrative towards patient care, meaning that the view of TMM on Exemplary Professional Practice proves accurate. Additionally, a clear need for improved communication amongst colleagues (collegialism) is discussed. Employees express that their current communication structure is limited to their tubes. TMM enables improved communication streams through Structural Empowerment, allowing for more involvement of healthcare staff in processes. Thus, TMM matches the views of employees at SUS regarding the improvement of communication.

Simultaneously, TMM also addresses the staff's need for inclusivity. As the empirical data suggest that especially lower personnel feel a strong need for inclusion. Structural Empowerment allows personnel to be involved in decision-making allowing their voices to shine through. Moreover, the employees at SUS believe that TMM will restore their motivation in their work by resolving the challenges they are currently facing. Although TMM does not directly expresses the improvement of motivation, it does state it will improve the work environment. The employees at SUS defined a good work environment as a source of information. Thus, TMM does not identify an increase in motivation as a core value, it does prove to be a positive by-product. This aligns the view of the employees with TMM.

TMM aims to reduce staff turn-over by providing a better work environment for the healthcare staff through structural changes. As employees at SUS often expressed their need for more skills and personnel. Furthermore, TMM aims to improve communication channels and include more personnel because of it. The improved work environment will increase the motivation amongst personnel, ultimately reducing staff turnover.

Mismatches between views and the model

This chapter will present the views of employees who had a different view than the rest of the organisation on TMM, as well as views that had a different outcome than the ones presented by TMM.

"So, it's still old wine in new bottles, to some extent."

-Alexander

This first quote identifies one of the takes on the meaning of the new model proposed by SUS. It puts the finger directly on the spot by simply mentioning that such a model is nothing new, simply another way of selling ongoing changes. This is further emphasised by Tova, the supporting manager, who says *"[…] even for the staff, The Magnet model is nothing new. What you do is still the same every day, it is just another way of thinking, given in a specific order."* Tova emphasised the statement given by Alexander, that these new changes will not cause any more pressure to the work of the nurses. Furthermore, she expressed that the new model will only give more structure to the working lives of the staff. Going further Tova mentions: *"I think it's important to talk about the magnet model. That it's not a rocket science."* With this quote Tova states again that TMM is not something difficult to understand, however crucial in a way where employees need to talk about it. Tova gives the researchers an anecdote on this model referring to Florence Nightingale who was a nurse in the Korean War: "[…] *where she was when they listened on Florence Nightingale, that say that you need to wash your hands, otherwise, you will take contaminate all the soldiers, we will have this cholera or whatever."* Tova expresses the fact that important results do not always have to be achieved by difficult solutions. However, these might be expensive in other ways.

"I think one challenge is that it will cost more money", Alice says. However, when money is involved, the big picture always needs to be clear for everyone, people are not going to throw money somewhere they do not know where it is going. However, no mention of amount expenses is mentioned. If we have to believe the opinions given by Tova and Alexander above, then the proposed changes do not have to cost anything, being more a change of mind set. However, as with any changes, management has to be on board with the changes.

"The board isn't even on board with the changes proposed, they don't, they don't settle down and listen, they just run right now. So, I sort of must pull them in."

-Alice

With many nurses being enthusiastic about the idea, the board is not even on the same page. Alice continued by saying in a meeting with them: *"Maybe we can do the magnet of Europe as well right now. And they were like No. I think that they're gonna get out on the other side pleased with it. They just don't understand it right now."* It becomes clear that the higher-up personnel do not believe the lower personnel have the knowledge to realise difficult changes and therefore do not see a need. With the top of the organisation not seeing the need for such changes, this can cause quite a bit of difficulty. As this decision organ must have the last say in the organisation, some nurses even question this.

Nurses say that managers still need to have the last say for decisions to be made, since "*some do not have the knowledge or decision-power to make these*", as said by Astrid. This is further voiced by Alice saying that there still always has to be a leader, "*some employees cannot, or are not comfortable taking decisions".* This clash in decision-making can also be observed in the positive aspects of the model. Herein, Tova and Sara contradict each other, by arguing that the implementation either leads to decisions without managers or decisions made by everyone in the organisation, all together. This clash in expectations still needs to be resolved, as both do have different outcomes for the result.

To conclude, TMM contains multiple matches with the views of the employees. Namely, improving communication, decision-making and the overall work environment, leading to increases in motivation and the reduction of turnover. However, mismatches occurred in the belief of a revolution and capabilities of decision-making. As can be read, there is a strong need for someone to impose these changes, the employees describe this person as a leader, or specifically a "Transformational Leader" as aligned with TMM.

4.3. Views on Transformational leadership

Through analysing the empirical data, the third theme, *view on transformational leadership*, was formed. As discussed previously, the interviewees had a strong view of the necessary changes. Therefore, interviewees stated their need for a leader figure that can realise these changes. This theme exists of what the expectations of employees are, how they describe the best leader for the model and lastly, a critical note on leadership is given.

Expectation of leaders

The previous chapters describe how change is looked upon and how the healthcare staff of SUS hopes to resolve challenges through the implementation of a model. The empirical data suggests that the implementation needs to be imposed by a leader figure. They expect leaders to stimulate them and help them grow further. Sara, the manager, describes that this generation expects more **inclusiveness**. This need for development and involvement is something that is emphasised by respondents. Astrid explained one of her most difficult experiences with a previous leader:

"*They (the staff) had a difficult time with the manager for several years. And the last one that was here did something that she got kicked off for. […] She was more like a sociopath. […] those people (staff members) she put them down. They had nothing to say, […] they were nothing to her.*"

-Astrid

The statement above was given in a disappointing matter proving an exception at SUS that all respondents would like to evolve away from. However, the need for a voice amongst healthcare staff has become apparent. Ebba addresses the importance for a leader to showcase soft values such as **caring** and **listening** to others. Maja positively addresses this further by stating that she expects to be led by a leader who is willing to listen to the healthcare staff. Challenges and change are phenomena that occur continuously. Therefore, Tova expresses that she believes it is important for a leader to be continuous. Alexander aligns himself with this view by stating "*[…] as a manager or a leader you need to be active and interested in transformation or* changes." From this, it has become apparent that the respondents expect aspects of continuity from the leader to develop themselves whilst simultaneously creating a better work environment in which **colleagues** are met with soft values. Besides the expectation of a leader portraying listening skills, education is an additional expectation for a leader figure. Agnes believes that leaders do not only need to be educated themselves but also expects the leader to educate other in their needs:

"*It is not enough to just tell people that they are allowed to have a decision-making ability. You must educate them*."

-Agnes

When asked further about what the respondents mean by **educating** them. Often the emphasis was put on personal development. Interestingly, when the respondents were

asked about what level of education, they expected from their leader the answers became vastly different. Ebba expresses this:

"I think it is important that a leader has a professional background that matches the group they lead. I think it is important to be able to understand the complexity of the situations to stand for him, and the challenges they are facing. And to be able to lead. I think it is important that the leader has the same profession, and preferably, higher, more efficient."

–Ebba

Understanding and supporting sufficiently becomes more realistic when someone has a similar professional background, as the challenges that are being faced are more familiar to the leader, according to Ebba. Therefore, they often referred to education to resolve challenges, believing that a highly educated leader has a better understanding of potential solutions. Alice states "*[…] my dream is, that to be a manager, you need to have a one-year master as well. Not if you go back to when I was educated, that the ward manager was always the elder […]*." Alice continues by stating that higher education often results in having a higher level of skill. These skills are of the essence to realise the respondents' needs for resolving challenges. However, Tova expresses similarly to Ebba that skills always need to be backed up by a medical background. It becomes clear that different employees value medical backgrounds more than others.

In addition to the expectations of leadership, the relational aspect of healthcare staff and leaders has been stated clearly, according to Alex. But since this is not their prime subject of expertise, a call for guidance in relationship management has become clear. Because of the high level of individuality in their tasks, the respondents expressed difficulty in maintaining relationships. Especially, if their voices are limited. Therefore, Maja expects the leader to demonstrate high levels of interactive **communication**. This implies that the relationships between SUS staff would improve by actively talking about their experiences, their development, and where their priorities at SUS lay.

Thus, the healthcare staff at SUS expects a leader to realise inclusivity by caring and listening to the needs of the staff. Additionally, the leader is expected to communicate well and support communications among colleagues allowing employees to educate each other and themselves in the process.

Characteristics of leadership at SUS

As can be read in the previous paragraph the respondents have many expectations of what a leader at SUS should portray. When questioned further about these soft values, the respondents started creating an image of the characteristics that a leader at SUS must possess.

It became evident that a leader in the healthcare sector needs to be patient-focussed as this inspires the staff members. Or in Emma's words: "*They (healthcare staff) have hope now […] the feeling of the leaders wanting to focus on the patients.*" Emma expresses further that it has become adamant that the leader's focus might have shifted towards economics more than towards patients. It appears that **patient orientation** poses an important characteristic, essential for a leader at SUS. As challenges within the hospital often lead to frustration, staff members seek additional **motivation**, "*You (Leader) need to motivate them (healthcare staff)*." It appears that Emma and her colleagues feel a need for someone to turn a hectic environment into a better workplace through means of motivation. Realising this task requires a very interactive role of the leader, implying a heavy reliance on consistency in a leader.

"*As a leader you can never lay down and say it is enough. You must work with it all the time […] you must create conditions but still be a leader in some ways. […] You need to be a leader for the structure. But you must make good conditions for the managers, and they put the nurses in that way. […] you must work with yourself all the time*."

-Maja

Next to leaders needing to be **good listeners**, Ebba also expressed that through education people not only expand their knowledge, but additionally learn to reflect differently. As everyone at SUS wants to develop and move forwards, it becomes clear that Ebba also expresses a need for leaders to look back and improve from there. Tova and some of her colleagues believe the aspect of being a good listener is also of the essence for a leader. Tova defines the quality of being a good listener as the characteristic of having "***Big ears***." In addition, she also states the importance of being willing to listen with **empathy**. Emma, the lead nurse, believes that a leader can only start listening and understanding the healthcare staff when leaders create an "*Open door*" policy. Astrid, the manager, sees herself as a leadership figure and believes that openness is one of the key characteristics of growth.

The empirical data points to two final closely interlinked characteristics. Firstly, Tova describes the current situation at SUS as a war, expressing that continuing developing

weapons will only prolong wars and not finish them. With this metaphor, Tova implies that small changes do not improve the current situation. War can only end when structural changes are implemented, and for this a leader is necessary. When questioned about what the leader needs to portray to ensure this, Tova expressed "*I think that the person needs to be very **self-confident**. […] the person also needs to be **brave**.*" All mention aspects of what a hero looks like. Going more into depth about what confidence entails, it became clear that confidence implies being aware of your limitations. Tova and her colleagues prove more experienced in certain areas and a leader should have the confidence to express their limitations. Even though only Tova expressed this phenomenon directly, many of her colleagues have experienced the feeling of getting surpassed by higher-ups throughout the years. Leading to the final finding based on the empirical data of Alexander. He states that charisma has been a key element of leadership for years. This characteristic can prove dangerous as it involves changing the way people think. However, when done correctly, leaders can create commitment. This commitment, like motivation, is necessary to keep people engaged according to the respondents. The creation of commitment through **charisma** is therefore seen as a tricky but important characteristic for a leader.

Needs for leadership

This paper's empirical findings are related to sub-theme of *needs for leadership*, as the healthcare staff holds expectations towards leaders and what characteristics a leader should portray. However, this paper conceives the needs of leaders that are necessary to realise structural changes at SUS. Additionally, other healthcare staff expresses what development they require to realise a supporting role for the leader. Alexander brings up an interesting point "*Reality is one thing, and literate is another, which also sparks a question, then what is what can you see a successful leadership?*" According to the healthcare staff at SUS a successful leader needs to portray the stated below.

Healthcare staff member requires a strong sense of **presence** from their leaders. Elsa expresses that she finds it important for a leader to be always present, as occasions occur where direct leadership might be needed. Therefore, Annika states that leaders also need to be accessible throughout the day, allowing interruptions to occur. The underlying aspect of attendance almost seems more important than making changes, as staff members portray the attendance of a leader as a possible solution.

It has become evident that some staff members feel surpassed by their lack of decision-making capabilities. Therefore, the need for equality rises highly depending on the relationship built between leader and staff. Or as Alice stated, "*[…] you need to have a*

just equal way of working with your staff." Tova adds to this by stating the importance of equality and relations through communication "***Communication*** *is very important […] ask more questions, say the answers.*" This statement implies that equal relationships can only be built through explorative communication in the form of questions. Throughout the interviews, it has become clear that a leader needs to develop relationships but needs to be provided with time and platforms to do this.

"*When you (leader) are there in your daily managing you need to be a role model as well.*"

-Tova

In few cases did respondents address their idea of a leader as a **role model** directly. However, throughout the empirical data, it becomes clear that many look up to the leader figure due to the high expectations that are being held towards a leadership figure. Because of this, a leader needs to be aware that the idea of being an equal leader is expected, whilst simultaneously be aware that this role is highly looked upon.

The empirical data shows the variety of views employees at SUS have of leadership. Due to the diversity in characteristics a leader at SUS should possess according to the staff, here follows a figure that shows the most important characteristics.

Characteristics	Motivator
Patient orientated	Present
Motivation	Role-model
Good listener	Educating
Emphatic	Communicative
Caring	Brave
Self-confident	Charismatic

Figure 9: Characteristic of transformational leader

Criticism on leadership

Throughout the interviews, the narrative on leadership was overwhelmingly positive. The perception of leadership could be described as a romanticization of the idea of a leader as a saviour to needs. This is interpreted as a feeling of heroism towards leaders. However, a more sceptical look at leadership was also found. Alexander describes "*Leadership has changed, some of the stuff around being convincing, encouraging, being nice, and trying to befriend people in terms of convincing them about to do things and all that.*" He further explains that the idea of such changes is often seen as revolutionary

and extremely driven by people who are involved in leadership development activities. "*But the relational aspect of leadership, that aspect that is actually targeting consideration the shared feelings, emotions in authenticity and all that has been around since the 60s, in leadership."* His statement indicates this romanticization of leadership where people believe that everything regarding leadership should be seen as revolutionary and a solution. Whilst concepts have often been around for decennia already, they are just presented differently.

When asked about the necessity of leadership, Agnes expressed that the survival of wards does not depend on a leader. As she states "*I think the ward can survive with a bad leader if they have a good, you know, group of people working together. But if you have a good leader, it is so much easier."* Although Agnes expresses the helpfulness of leaders, she was the only healthcare staff member to express that leaders are not necessary for the survival of an organisation. Following the reasoning of Alexander, it is logical that the survival of wards does not depend on leadership, as initiatives regarding leadership often fail in practice. Therefore, this draws an interesting contrast to the healthcare staff at SUS who have expressed feelings of enthusiasm and possibilities with new leadership styles. Uniquely, this wishful thinking about leaders and leadership is exactly what Alexander describes as an issue with modern takes on leadership.

> "*And I think that leadership has become increasingly, receiving and used as a way of compensating for that wish to be in a particular community and to gain some sort of meaningful life."*
>
> -Alexander

Maybe unaware himself, Alexander addresses here exactly what is happening at SUS right now. Individuals seek meaning, in the case of healthcare staff, meaning in their work. Current challenges stop them from obtaining this meaningful life, resulting in the search for resolutions. The resolution is sought in a hero-like leader that will resolve challenges and restore the meaningfulness of their work, but Alexander disagrees.
All in all, the empirical data shows that the perception of leadership differs greatly between the healthcare staff at SUS and a professor in Business Administration. Where both parties agree that leadership can have a significant impact on the work environment. Alexander warns of the dangers of romanticising leadership by seeing it as an ultimate solution. Especially given that most modern-day leadership developments are simple repetitions of already-established ideas. Therefore, the field of leadership has changed and will remain to do, but if these changes pose new ideas remains to be discussed.

5. Discussion

This chapter aims to put the findings from the previous chapter in context using the literature presented in Chapter 2. Firstly, this chapter will conclude the views of leadership by SUS employees and compare this to TL from TMM.

5.1. Leadership views versus transformational leadership

This subchapter will present the empirical findings together with the literature found on (Transformational) leadership. As leadership contains vast literature on social sciences and the humanities (Alvesson, Blom & Sveningsson, 2016; Marturano & Gosling, 2008), it can only be understood through interpretation verifying how leadership is made sense off (Prasad, 2017). Interestingly, the researchers found ample disagreement between the academic literature on TL and the empirical data, confirming the academic literature. Therefore, this subchapter aims to provide the reader with a discussion on where matches and mismatches are found between the views of employees at SUS and TMM.

As could be read in the previous chapter, the employees at SUS defined characteristics that they associated with good leadership (figure 9)

Characteristics	Motivator
Patient orientated	Present
Motivation	Role-model
Good listener	Educating
Emphatic	Communicative
Caring	Brave
Self-confident	Charismatic

Figure 9: Characteristic of transformational leader

Leadership is believed to have a significant impact on organisational operations (Alvesson, Blom & Sveningsson, 2016; Yukl, 2012). Employees at SUS align themselves with this idea by addressing a leader as a necessity to improve their current work environment. However, the healthcare staff stated that not every leader is fit to lead in the hospital, only leaders who show the characteristics above are deemed fit. The characteristics named are portraying soft values, which is logical considering their need for breaking down current hierarchical structures and changing them to a supportive

work environment. As Alvesson, Blom & Svenningsson (2016) further claim in their book, leadership has shifted from individual leadership styles to more focus on behaviour and relationships between followers and leaders. Based on the need for soft values stated above, it becomes adamant that this relationship leadership style has not been fully integrated within SUS yet.

The empirical findings show a clear need for relational and individual improvement of the employees. Moreover, this indication of leadership as a tool for growth disassociates itself from control through power and organisational goal orientation. This correlates with Alvesson, Blom & Svenningsson (2016) as they state that leaders maintain relationships with followers, indicating that followers do this voluntarily. Whereas managers, are associated with task orientation and do not have a voluntary relationship. When the empirical findings are taken into consideration, both SUS and its employees view patient care as the primary goal, with personal development to reduce staff turn-overs following close behind. Alongside portraying soft values, a leader is expected to provide a work environment in which SUS's and its employees' goals are aligned. When these exact needs are compared to the six emotional leadership styles of the leadership book *Primal Leadership* (2009), a strong connection to a *coaching leadership style* becomes apparent. Therefore, based on the empirical data collected from the interviews, a coaching leadership style seems to suit the needs of SUS's employees best. Which sparks interest in how the employee view aligns with TL.

Following the timeline, a unique phenomenon is found. Managerialism, focusing on hands-on top management, explicit formal measurable standards and measures of performance and success & improved output of control, developed itself around the 1970s (Hood, 1995). Roughly a decennia later symbolic dimensions of leadership that focus on moving beyond human tasks and task orientation started to develop (Alvesson, Blom & Sveningsson, 2016; Aslamazishvili, Ignatova & Smirnaya, 2020). The phenomenon of validation beyond task orientation is something nurses especially have been dealing with throughout the last few decennia. The collected empirical data suggests that this search for validation and motivation is as lively as ever, with nurses highly requesting leadership to bring back pride to the profession. Hence, a change of culture is of the essence. The idea of moving beyond task orientation, focusing on a positive working culture (good work environment) aligns with TL in TMM.

In TMM, TL is defined as going beyond the perception and influence of an individual and binding them together to realise organisational culture changes (Grohar-Murray, DiCroce & Langan, 2016). Moreover, one such cultural change TL focuses on is improving the

leader-follower relationship. Uniquely, the values that are defined as essential for this relationship portray mostly soft values as inspiration, emotions, loyalty and commitment to empower and support (Alvesson, Blom & Sveningsson, 2016; Grohar-Murray, DiCroce & Langan, 2016). This phenomenon is unique because it seems to directly target the soft value needs that healthcare staff are requesting today. However, TL reasons this because of its importance in preparing employees for future goals set by senior employees. Therefore, this aligns more with Goleman et al's (2009) idea of *the pace-setting leader*. It becomes clear that when comparing the leadership requested by the employees at SUS with TL they are not fully aligned.

Although both TL and the employees at SUS emphasize the importance of improved leader and follower relationships through soft values, the soft values requested are different. The biggest difference is that employees at SUS have requested strong communicative skills, whereas TL does not seem to address such soft values. Additionally, SUS's healthcare staff views align the most with a coaching leadership style, where TL is used to empower employees to achieve pre-set goals for the organisation. Therefore, a clear misalignment between what employees at SUS perceive as TL and TL are different.

5.2. Leadership versus TMM at SUS

When looking at the view of leadership presented above, one main question arises:

Will this view of leadership suit what the organisation is looking for in the form of implementing TMM?

To answer this question, multiple elements must be addressed first. Starting with the type of change presented. "*Transformational change occurs in response to, or anticipation of, significant changes in an organisation's environment or technology*" is a quote from Cummings and Worley (2009) stating the reason why organisations undergo transformative changes. In the findings, it becomes clear that SUS is facing these transformative external changes in the form of 'industry discontinuities' (Tushman, Newman & Romanelli, 1986), with employees naming that the ageing population and increase in administrative tasks to shortages of personnel, require transformational changes as experienced by healthcare staff. These kinds of changes are, as stated in Palmer et al. (2016), planned changes. Given that the current implementation does not

simply change tasks, but the entire work environment including the relationships in this environment, the implementation will prove a time-consuming process.

Moreover, Balogun and Johnson (2004) support the idea of planned changes as the implementation of a broad systemic change model highlights the social nature of schema. This implements a broad systemic change model highly dependent on communication. Comparing this to the context of SUS, it becomes clear that the tube system forms a blockage to external tube communication. This phenomenon poses a threat as communication is the reason why so many change processes fail (Thomas J. Peters & Robert H. Waterman Jr, 2006). Therefore, although TMM aims to improve internal communication, the implementation of this model will prove highly challenging. Additionally, the empirical findings indicate a strong sense in differences of operations among SUS's staff. Given that broad systemic change models cover many aspects of an organisation, contextual changes are demanded (Balogun & Johnson, 2004). SUS presents itself as a professional organisation with a variation in work processes due to the tube system allowing for specified work processes. The implementation of a broach systemic change model may be problematic as plenty of peculiar changes within SUS's context are required. Furthermore, changing the local context to the demands of a model proves more difficult as it emphasises changing the diverse context of the hospital.

When analysing the healthcare staff's view of the findings, they suggest that employees feel like changes are being implemented at a slow pace. This results in, according to them, declining motivation for their work as they are not changing towards improved conditions in a quick enough pace. Because of the declining motivation many nurses "changing shop" or simply leaving the organisation all together, according to the empirical findings.

However, Kotter (2012) suggests that: *"organisations either change rapidly or perish, while on the other hand it is advised to avoid the risk of implementing too much change all at once"*, this is then further emphasised by Buch and Menges (2010). Here it can be seen that employees feel that changes need to be implemented as quickly as possible to make sure employees do not switch jobs immediately. However, with such changes, it is important to, like Kotter (2012) suggested in Palmer et al. (2016) not overlook minor changes to the organisation that will lead to the "high impact changes". Herein, nurses are actively trying to implement minor changes. Three nurses mention that they are researching to improve the working condictions of nurses on the work floor, However, the implementation of these is often stuck at a higher level who don't have the time due

to being busy with more important changes. Ironically, this limitation of power and voice to realise changes is exactly what the healthcare staff at SUS is wanting to change.

Now that the type of change at SUS has become clear, the impact must be addressed. Multiple elements have been made clear of what employees hoped that TMM will address, as can be seen in the previous chapter. One of these is the currently maintained tube system, limiting communication amongst colleagues who fall outside of their tube. TMM aims to target the outspoken need from healthcare staff for improved communication, by focusing on tearing down hierarchical tubes and flattening the organisation. According to TMM this can be achieved through internal communication and shared structural decision-making, answering the employees' request for more involvement in decision-making.

TMM's focus on collegialism (Grant et al., 2010) does simultaneously pose challenges in itself. By actively involving healthcare staff in the decision-making process (shared governance) internal communication will improve. As perceived by the interviewees, meetings in which decisions are discussed can also lead to exchanges of knowledge. For example, current situations and challenges of other wards/departments can be given. These exchanges will allow colleagues to grow closer and move away from vertical limitations. However, SUS is planning on imposing professional governance, a form of governance that does the exact opposite. Since professional governance allows for individual decision-making and creating ownership of decisions within routine works (Kuhlmann, Allsop & Saks, 2009). When individuals are allowed to take decisions, the communication flow limits itself to one-on-one communication between colleagues. This would change the vertical tube system to a horizontal system. Moreover, the focus on ownership of decisions implies accountability for which the individuals become responsible. With the focus being on ownership of decisions and making employees accountable, the area of interest stays around managerialism (Alvesson & Sveningsson, 2011). Ironically, this managerialism and its focus on accountability is exactly what TMM tries to tackle. The individual decision-making does allow for healthcare staff to not only be the professional expert within their area but act according to it. Thus, professionalism allows employees to work independently within their routines (Office of the Superintendent of Professional Governance, 2019), however high levels of individualism limit the sense of collegialism on the work floor as employees are more focused on their profession and how they operate within it. Although empowerment is one of the challenges mentioned by nurses, an additional challenge was also addressed.

Briefly mentioned before, the vertical structure of the hospital poses a challenge for most nurses in their work. The nursing staff believes TMM will address this vertical mode of operating. Structural empowerment of which shared governance is a tool, states that dependency on managers will decline, due to empowerment of the nursing staff. (Another Living Legend - O'Grady Discusses Professional Governance, 2022). This empowerment of nursing staff aims to break down the tubes and create a more horizontal workflow, in which decisions are being made on an equal level between managers and other healthcare staff members, such an organisation is called the professional organisation as according to Mintzberg (1992). Thus, TMM is "breaking down hierarchies". Breaking down these hierarchies will reduce the need for middle managers, whose primary task is to enforce accountability over the different levels of the organisation (Bourgault & Van Dorpe, 2013). Consequently, the current managerialism will disappear, making place for a professional view (Alvesson & Sveningsson, 2011; Bhardwaj, 2022). Especially nurses express their hopes in TMM being able to achieve such a shift towards a more horizontal environment.

The shift towards the horizontal environment whilst simultaneously requesting strong leadership is the biggest mismatch TMM proposes. As suggested by Kotterman (2006) and Marturano & Gosling (2008) employees at SUS often use the terms managers and leaders interchangeably, where some employees believe their managers to be leaders. Others strongly express their beliefs of everyone being their leader, but simultaneously do agree on the idea of leaders as problem solvers, who in the current structure are higher-ups. When analysing the empirical findings, it became evident that healthcare staff described leaders as someone who could support and provide a vision for them to follow. It became apparent that employees at SUS are romanticizing the idea of a leader, almost hero-like. Therefore, strong elements of choice and voluntary followership in their role can be found. However, the relationship between leader and follower implies vertical modes of organising, referring to elements of hierarchy with followers being dependent on their leaders (Alvesson, Blom & Sveningsson, 2016). Thus, the idea of moving towards a more horizontal organisation whilst maintaining the idea of hierarchical superiority in the form of a leader seems highly contradictory. Although it becomes clear that employees at SUS want to get rid of the goal orientation imposed by managerialism (Nayar, 2013) and move towards a more supportive role in the form of a leader. A leader will remain a vertical mode of organisation amongst healthcare staff that request horizontal structures.

Uniquely, SUS expresses its current involvement in the Magnet course as something revolutionary and a way to finally start functioning as a hospital should. From the

empirical data, it becomes clear that functioning the way it should implies that professionals have jurisdiction over the patient when it comes to their area of expertise. Furthermore, TMM is often portrayed as a revolutionary tool, to demonstrate what the future of healthcare should be (Grant et al., 2010). It becomes adequate that almost everyone involved in this process is appraising TMM as something that will resolve many of the proposed changes mentioned earlier. However, the appraisal of the shift from accountability to collegialism can be viewed as ironic. As the proposed revolutionary tool is bringing the operations in the healthcare sector back to the past, before the shift to managerialism (Alvesson & Sveningsson, 2011; Risse, 1999; Spanò, Tomo & Parker, 2021). The emphasis on collegialism and professionalism is often described as traditional by academic literature. Thus, the healthcare revolution as mentioned by the change coordinator in the preliminary interviews, is a revolution that will bring the healthcare sector back 60 years. However, through the emphasis on the role of nursing, the nurses' request for motivation might be resolved as TMM finally addresses issues that nurses have been facing for decades (Another Living Legend - O'Grady Discusses Professional Governance, 2022).

Discussion – summary

Considering the question stated above and analysing whether the view of leadership will suit the organisation, serious mismatches can be observed. SUS's staff requested a need for a leadership figure in the form of a supportive coaching leader, which devalues the idea of a horizontal organisation. As nurses want to take ownership of their own decisions within their profession, a vertical mode in the form of a leader brings hierarchy to a horizontal organisation. In a way, the employees are looking for vertical guidance, while the model suggests a horizontal structure.

This way of thinking is not looked for by all nurses at SUS. Agnes states that her ward can survive without a manager and "*does not see the need for one herself."* Agnes acknowledges the value of leaders, but she is the only member of the hospital staff to argue that they are not essential to an organisation's survival. The survival of wards does not depend on leadership, according to Alexander's theory, because attempts at leadership frequently fail in practice. Alexander specifically identifies a problem with contemporary views on leadership as wishful thinking about leaders and leadership.

As can be observed above, there are a lot of positive matches between TMM and what the organisation hopes to achieve. However, the sense of leadership and (shared) / professional governance have proven to be contradicting the organisation's needs, as

can be read above. Simultaneously, the requests from the healthcare staff seem to contradict themselves at times. It becomes obvious that SUS and its staff members see TMM as a best practice for adapting their situation to this model instead of the model adapting itself to SUS's situation. This should prove possible as TMM states to be a highly adaptive model (Grant et al., 2010). As of now, the current situation does barely seem to be considered, even though SUS has proven to already have successfully implemented some elements of TMM. Therefore, the employees are looking for something that may not work well with the kind of organisation they want, once more creating a misalignment between employee and organisational goals. Furthermore, the broad systemic model demonstrates a misalignment by containing elements that contradict each other. The implementation of TMM can therefore not target all challenges faced by SUS's employees.

6. Conclusion

This research aimed to answer how leadership influences the implementation of an all-encompassing model in the healthcare industry. The research question aimed to analyse how employees of a healthcare organisation perceive leadership in this all-encompassing model, to which matches and mismatches were found. The perceived view of leadership was put up against 'what this model hoped to address in the organisation' and 'what the organisation needs. By drawing upon these points, this chapter provides a summary of the empirical findings and the contributions to the literature. Finally, this research addresses the limitations of this research and makes suggestions for future research.

6.1. The change at SUS

This research has addressed that the health sector is facing a plethora of challenges. The sector is struggling to keep up with the changing demographics, in the form of an ageing population, which increases the need for quality drug development, increasing the prices (World Health Organization, 2021; Wu & Green, 2000). Another burden fell on the industry with the recent COVID-19 Pandemic, causing many nurses to overwork, catch long-covid or leave the hospital (Adhanom Ghebreyesus, 2020; Donthu & Gustafsson, 2020). At SUS these industry challenges were not unnoticed and put pressure on the already fragile nursing system in the hospital. Limited communication between departments and limited room for improvements, combined with shortages of professional staff in the healthcare sector resulted in many nurses 'changing shop', therefore increasing staff turnover. *Thus, change was inevitable.*

The change came in the form of a model focuses on Magnetism for nurses. Magnetism focuses on improving the working conditions for nurses in the hopes of nurses maintaining in the organisation. Consisting of 5 magnets to retain nurses; Transformational leadership, Structural Empowerment, Exemplary professional practice, New Knowledge, innovations and improvements, and Empirical outcomes (Grant et al., 2010). The components are build-up out of Forces of Magnetism, thus attracting nurses. Maintaining the five pillars allow for nurses' empowerment, decision-making and boosting of morale, which in turn will lower the high turnover rates in the healthcare sector. This 'broad systemic change model' would on paper fulfil all the challenges SUS is dealing with. However, these fulfilments may be problematic in terms of local conditions for SUS.

This model, mainly focused on recreating structure and putting emphasis on collegialism, can be seen as a socially engineered model. But may perhaps not quite be designed for the context of SUS. These contexts entail the need for SUS staff to look for vertical guidance and the shift to professional governance. With the search for a leader, in the form of a hero-like figure, the employees undermine the foundation of TL in the model in question. Namely, being centred around taking a more horizontal stance towards leadership. The search for a leader does not take away hierarchies in the organisation, but more than that, it gives these levels another meaning, namely in the form of a coaching leadership style. As can be seen, this is quite contradictory to the aim of TL and does raise the question of whether the model as a whole should be implemented or only parts of it.

Added to this, SUS's employees express on many occasions the need for a shift to professional governance, in which they can work independently without much managerial help. This individual decision-making limits the aim of the model, being focused on creating an inclusive atmosphere where collegialism is centred. Thus, in a way limiting the sense of collaboration that many employees see as a benefit of TMM. Thus, the irony of this broad systemic change model is its aim for horizontal operations and empowerment, whilst including TL as a vertical mode of organising in the same model.

These local conditions pose an issue for the implementation of this model, as what is sought by employees will not be addressed by the model. Thus, too many idealistic assumptions were made of this model, in a way that it could solve all of the challenges presented by the healthcare staff. In a way, TMM is a model that will address many of the challenges that SUS is dealing with. However, decisions have to be made about the two contradictions. In theory, the organisations could not adapt to both, so two options remain open. Either adapting the new form of leadership, proposed by the employees, to help the employees in their shared decision-making. Or the change to professionalism is optional, where employees become their leaders, thus breaking down the verticality.

Therefore, a seemingly good match may contain elements that pose as popular best practices but prove to be poorly aligned with other parts of the model (the professional part). Furthermore, although these misaligned parts pose themselves as suiting for current needs in the healthcare sector, they do not necessarily prove to match well with local reality/conditions. Thus, the change plans appear appealing but may be quite misleading.

6.2. Theoretical contribution

As stated in the methodology chapter, the nurse's interpretation of leadership in the healthcare sector remains a topic to be explored within social science research (Another Living Legend - O'Grady Discusses Professional Governance, 2022; Porter-O'Grady, 2001). Additionally, this paper argues that TMM is built to resolve challenges that the nursing sector has been facing for decades, but is not addressing them correctly given its lack of recent collected empirical data (Grant et al., 2010). Therefore, this paper also aims to address matches and mismatches between how the healthcare staff today views leadership and how TMM addresses it.

Firstly, this paper explored the nurse's view on leadership and finds itself aligned with previous studies of modern leadership due to the views focusing on leadership as a supportive role in which soft values are portrayed (Alvesson, Blom & Sveningsson, 2016; Kouzes & Posner, 2023; Yukl, 2012). While this paper concludes that the healthcare staff at SUS aligns itself well with modern literature on leadership, it becomes clear that the line between managers and leaders is not as well defined as academic literature suggests (Alvesson, Blom & Sveningsson, 2016; Kotterman, 2006; Kouzes & Posner, 2023; Marturano & Gosling, 2008; Nayar, 2013; Yukl, 2012). Following this empirical finding, this paper argues that nurses at SUS especially want a leader to portray soft values and support them. Simultaneously, the nurses look upon this leader as a hero-like individual who improves performance and uses their power to provide better working conditions, implying managerialism. The idea of managerialism in a leader contradicts the idea of a leader heavily relying on evolvement through the passing and development of cognitive skills (Grohar-Murray, DiCroce & Langan, 2016).

In addition, this paper contributes to the social sciences by aligning matches and mismatches between the empirical findings and Grohar-Murray et al's (2016) & Simpson's (2007) theories on TL as suiting for TMM. This paper's findings support the existing theory by the healthcare staff portraying needs for honesty, supportiveness, cooperativeness and inspiration similar to Grohar-Murray et al's (2016) theory. Additionally, the findings add a need to the theory, namely the characteristic of a role model. The interpreted idea of a role model aligns with Simpson's (2007) five key actions of leadership, emphasising the aspect of modelling the way. Moreover, this paper addresses the need for increased communication in the leader-follower relationship. With this, the combination of existing cooperativeness and new communication allows for increased levels of knowledge exchange fulfilling the need of healthcare staff, according to this same healthcare staff. On the other hand, these differences imply that current

healthcare staff argue for the image of a leader that does align with TL, thus believing TL not to be the best-suiting leadership style for TMM in contrast to what current literature suggests (Grant et al., 2010).

6.3. Limitations

This research addressed the view of the healthcare staff regarding leadership at SUS and compared this view to the leadership style as presented in TMM. Furthermore, the matches and mismatches between the healthcare staff at SUS and TMM were addressed to point out difficulties in the implementation of the change programme. Although the limitations were already discussed in the methodology chapter, this paper considers external impacts that can have influenced the results once more.

Since both researchers are familiar with the concept of leadership but have limited knowledge of the healthcare sector, the preliminary knowledge of this research was inadequate. Moreover, this entails that all gathered knowledge of the healthcare sector is obtained over the course of this research, affecting the depth to which analysing was possible.

Additionally, the conducted semi-structured interviews posed various difficulties for this research. Firstly, the researchers were not able to contact the interviewees directly, enforcing a time-pressured period in which the conduction of interviews was possible. This limited the time in which questions could be changed for the specific interviewee. Furthermore, the contact through a third party to reach the targeted interviewees put additional pressure on the researchers themselves. As all interviewees were non-native English speakers a language barrier occurred, forming a blockage of the depth fullness in which answers were provided. Regardless the answers provided by the interviewees prove valid.

Finally, this research adapted single-case research at SUS. Because all findings are connected to the healthcare sector, this entails a limitation to this same sector. Thus, the findings presented cannot be applied across a multitude of industries. However, the presented findings do heavily criticise managerialism and promote a switch back to professionalism, a phenomenon that is becoming more prone in modern society. Therefore, the idea of returning decision-making capabilities to the professional working with the made decisions can be generalised.

6.4. Future research

Following the findings and limitations presented throughout this paper, future research is of the essence to create a generalisation of this paper's findings. Given the limited time in which this research can be conducted a more depth full research containing a broader sample size of interviews is necessary. Because the hospital contains many departments, units, and wards, it is difficult to imagine how every area of the hospital will be affected by the implementation of structural empowerment. Further, research is required to discover the individual needs of each hospital part, to adjust TMM as a tool to the requested situation.

Furthermore, given that the implementation of magnet programmes proves a relatively new phenomenon in Europe, little to no data is accessible. Thus, no generalisations over the effectiveness of the implementation of TMM can be made yet. Although this research agrees that TMM targets challenges faced by healthcare staff today, the potential increase of effectiveness in patient care remains to be further researched.

Lastly, the request for a decrease in managerialism and more involvement in organisations through professionalism is limited to the healthcare sector by this research. However, the researchers expect that the phenomenon of replacing accountability and individualism to professionalism and collegialism is not necessarily limited to the healthcare sector. Therefore, cross-sector research is needed to further generalise this potential revolution of the past.

6.5. Practical implication

The findings presented in this paper indicate certain practical implications, in particular the role of a leader in SUS, and how this leadership role works alongside structural empowerment. When both implications are done correctly, a result of more motivated and involved nurses is to be expected. This, causes nurses to stay within the hospital and their profession, therefore decreasing the personnel shortage. This paper proposes that the leadership figure requested by the healthcare staff should adjust themselves to the role of a supportive figure, like a coach. As a coach may motivate and allow for personal development to occur, answering the biggest needs of the healthcare staff. Simultaneously, it is important that this leader figure finds a way to align the personal goals with the organisational goals to stimulate the requested development and reach the overarching goal of increased patient care.

Additionally, this research also highlighted the mismatches between leadership and structural empowerment in TMM. Given that the original Magnet Model focuses on shared governance with a supportive and goal-orientated leadership style, it allows for shared decision-making and hierarchical guidance at the same time. Because SUS wants to implement professional governance, focusing on ownership of decision-making and individual decision-making, the hierarchical element of a leader seems to contradict. As the idea of a hierarchical element in a model that aims to flatten the organisation seems ironic. Therefore, it is important to implement either shared governance with coaching leadership aspects, or professional governance with individuals being their leaders. Based on the strong request for visions and guidance a form of shared governance with coaching leadership elements seems to target the right elements of motivation and support to fulfil the needs of healthcare staff and reduce the turnover rates.

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