Understanding avoidant leadership in health care: findings from a secondary analysis of two qualitative studies

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Understanding avoidant leadership in health care: findings from a secondary analysis of two qualitative studies

Aim To illuminate ways that avoidant leadership can be enacted in contemporary clinical settings.

Background Avoidance is identified in relation to laissez-faire leadership and passive avoidant leadership. However, the nature and characteristics of avoidance and how it can be enacted in a clinical environment are not detailed.

Methods This paper applied secondary analysis to data from two qualitative studies.

Results We have identified three forms of avoidant leader response: placating avoidance, where leaders affirmed concerns but abstained from action; equivocal avoidance, where leaders were ambivalent in their response; and hostile avoidance, where the failure of leaders to address concerns escalated hostility towards the complainant.

Conclusions Through secondary analysis of two existing sets of data, we have shed new light on avoidant leaderships and how it can be enacted in contemporary clinical settings. Further work needs to be undertaken to better understand this leadership style.

Implications for nursing management We recommend that organizations ensure that all nurse leaders are aware of how best to respond to concerns of wrongdoing and that mechanisms are created to ensure timely feedback is provided about the actions taken.

Keywords: avoidant leadership, health care, leadership, secondary analysis

Introduction and background
Optimal clinical environments rely on open and transparent processes through which concerns can be raised, fully investigated and appropriately responded to. Most health-care facilities have a reporting line identifying the appropriate persons to whom concerns can be taken, and though nurses are urged to report matters
of concern to their managers, little is known about nurses’ experiences of doing so. This important element of professional behaviour has not been adequately scrutinized in the literature. However, there is evidence to suggest that concerns raised by nurses and other health-care professionals may not always be dealt with appropriately by those with whom such matters are raised (Firth-Cozens et al. 2003, Attree 2007, Hutchinson et al. 2008). In this paper, we reanalyse data drawn from two qualitative studies and use this as a lens to explore leader responses to concerns raised by nurses, and conceptualize the responses as avoidant leadership.

Avoidant leadership is a term that is seen in the literature but is seldom defined. Typically, nursing scholars and researchers have focused upon transformational and transactional leadership styles with little attention directed to understanding avoidant leadership. Avoidance is identified in relation to laissez-faire leadership and passive avoidant leadership (Horwitz et al. 2008, Cummings et al. 2010). However, although there is reference to avoidance, the nature and characteristics of avoidance and how they can be enacted in a clinical environment are not detailed. There has been little attempt to examine in detail the nature or consequences of avoidant leadership in the nursing workplace, or to determine the contextual factors that moderate the capacity to engage in various styles of leadership. For the purposes of this paper, we define avoidant leadership as occurring where leaders do not act responsively, efficaciously or decisively to effect positive change.

Aim

The aim of this paper is to illuminate ways that avoidant leadership can be enacted in contemporary clinical settings. The experiences of clinical nurses raising concerns about workplace wrongdoing were used as an exploratory lens to better understand and detail the leader behaviours that comprise avoidant leadership.

Methods and data collection

This paper presents the findings of a secondary data analysis employing data collected from two distinct studies that shared the feature of exploring nurses’ experiences of workplace wrongdoing. Study 1 examined nurses’ experiential accounts of whistle blowing and study 2 sought to reveal the experiences of nurses’ exposed to bullying in their workplace. The studies shared many methodological features (Table 1). Both studies were underpinned by the tenets of qualitative research that acknowledged the personal meanings of subjective experiences of participants as revealed through their accounts of the phenomena of interest (Streubert Speziale & Carpenter 2010). In-depth qualitative interviews were conducted in both studies and lasted between 40 and 120 minutes. Findings from both of these primary studies have been published elsewhere (Hutchinson et al. 2005, 2006a,b, 2010a,b,c, Jackson et al. 2010a,b, 2011).

Initially, the qualitative data used here was generated through two distinct inquiries that focused on similar topics using comparable research methods. Analytical integration of qualitative data sets from these two studies allowed for further investigation from which a synthesized account of the concept avoidant leadership emerged. For this current paper, both sets of qualitative data were reanalysed to answer questions related to the role and responses of clinical leaders in the initial management of workplace wrongdoing, specifically, ‘How did leaders demonstrate avoidant leadership when these nurses raised matters of concern?’ In this approach, the contribution of each data set was of equal value, and both data sets were reanalysed to provide a richer explanatory account of avoidant behaviours in clinical leaders.

Analysis

Analysis of the data followed the tenets of thematic analysis. In this case, the abstracted themes were revealed using the same approach used when analysing interviews successively (Miles & Huberman 1994, Boyatzis 1998). First, each data set were separately read and re-read. The researchers re-immersed themselves in the transcripts seeking data that focused on the participant’s descriptions of the manager’s responses to the event. The data sets were decontextualized or reduced and recontextualized (Boyatzis 1998). Data reduction included analysing and coding each data set independently, so two sets of tentative codes were developed. An iterative process ensued and themes were developed using both data sets. There was deliberate flexibility during development of themes and they were revised based on emergent codes, ideas and new description. This process enabled the identification of commonalities and overarching themes. Emerging from the independent analyses of these data sets was a similar thematic thread that had resonance with both data sets – the avoidant responses of nurse managers to concerns raised.
Table 1
Methodological features of the two studies

<table>
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<tr>
<th>Methodology</th>
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<tr>
<td>Study 1</td>
<td>Qualitative</td>
<td>Digitally recorded and transcribed</td>
<td>Nurses with first hand lived experience of whistle blowing, either as a whistle blower, the subject of a whistle-blowing complaint, or as a bystander to a whistle-blowing event</td>
<td>Self-selecting participants to respond to a media invitation</td>
<td>18 enrolled and registered nurses</td>
</tr>
<tr>
<td>Study 2</td>
<td>Qualitative</td>
<td>Digitally recorded and transcribed, semi-structured, open-ended interviews</td>
<td>Nurses with first hand lived experience of bullying either as the subject of bullying or as a bystander to bullying</td>
<td>Self-selecting participants to respond to a media invitation</td>
<td>26 enrolled and registered nurses</td>
</tr>
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</table>

Secondary analysis of data

Secondary data analysis enables researchers to ask new questions of extant data sets (Corti 2007, du Plessis & Human 2009). While data mining and secondary analysis of quantitative data is well-represented in the literature, (Thompson 2000, Doolan & Froelicher 2009) there is very limited discourse detailing accepted processes and methods that can be used to re-explore existing qualitative data, and little in the literature that guides qualitative researchers when more than one data set is analysed. Typically, qualitative interviews seek to gather data about experiences or personal meanings in order to answer a research question. These interviews also capture contextual information and stories related to the research focus. There is implicitly a wealth of information that is often under-explored and under-utilized (Corti 2007). This under-explored data can yield new insights that may not be revealed unless a different question is asked of the data and a fresh lens is applied. Secondary analysis of data sets can answer new questions that are compatible with the original aims of the project. Secondary analysis of rich qualitative data also provides an opportunity to further the ethical principle of justice, as participants’ contributions and stories are more fully explored and reported. Further, it has been argued that undertaking secondary analysis of narrative data about highly sensitive topics has the ethical benefit of avoiding further potential distress to vulnerable participants (Fielding 2004).

There are three broad approaches to secondary analysis of research data. The first, triangulation, involves exploring complementarity between the results from one data set to enhance, illustrate, or clarify the results from another (Morse 1991). The second, combing, involves one data set being subsumed into another and the blended data being analysed. The third approach is integration in which the individual integrity of both data sets is retained while their inter-dependence is analysed, allowing researchers to gain richer perspectives and add scope or breadth to what is understood about a concept (Creswell & Plano Clark 2010). Integration can occur at a number of stages. In the analysis presented in this paper, analytical integration of two qualitative data sets occurred at the point of secondary analysis and interpretation.

Participants

All participants were nurses who were currently working, or who had worked, in a health service in Australia. The combined sample size was 44, comprising 18 from study 1 and 26 from study 2 and had years of nursing experience ranging from 2 to 40 years. Participants had wide clinical experience and were drawn from critical-care areas, mental health, aged care, medical/surgical and community settings.

Ethics

Both studies received ethics approval from relevant human ethics committees. Participants were asked for their consent to use their data for research purposes and subsequent publications. Owing to the highly sensitive nature of the data, however, it was important that the participants’ data were anonymized before data analysis commenced. Only the researchers who undertook original data collection knew identifying details of the
participants or the health services involved in the events. To further ensure the protection of the participants and the health services, the data sets were read closely for potentially identifying information and this was removed.

Rigor

Trustworthiness of this secondary analysis is supported because both of the original studies were underpinned by the same research tradition, and the focus of the data sets is compatible with the current research question (du Plessis & Human 2009). This enabled a coherent approach to data analysis. Confirmability of the emerging codes and themes was supported by the participants’ similarities, (Thompson 2000) the depth of description in both sets of data, and the concurrence between researchers during data analysis. Credibility was established because the themes were revealed in both data sets.

Findings

Participants described a range of serious concerns they had attempted to raise, and these included diverse matters such as inappropriate use of narcotics, abusive and threatening behaviours within work teams, unsafe patient acuity levels, hostile workplace behaviours that compromised patient care and unsafe clinical practices. When raising concerns participants reported unexpected leader responses. These nurses had felt they were fulfilling their obligations to follow organizational processes in reporting concerns or wrongdoings appropriately and in many cases had expected to garner support and validation of their concerns. However, from our analysis, we have identified three forms of avoidant leader response: placating avoidance, where leaders affirmed concerns but abstained from action; equivocal avoidance, where leaders were ambivalent and inefficacious in their response; and hostile avoidance, where the failure of leaders to address concerns escalated hostility towards the complainant. These forms of avoidant response are explored more fully below.

Placating avoidance: ‘she would not tolerate that in our ward’

In exhibiting a placating response, participants reported their managers initially appearing to be receptive to concerns, and pledging to take some sort of action. Participant B6 reported a very positive initial reaction; ‘She [manager] was great. She said oh, no, she would not tolerate that in our ward’. After this initial complaint, when met with this response, participants would leave their manager’s offices feeling optimistic, positive, validated that their concerns had been treated seriously and respectfully, and with the expectation of some sort of corrective action.

However, as time passed, with no apparent action or changes in the situation, participants felt increasingly let down and disappointed. In these cases, participants would have to repeatedly raise the concerns, each time feeling a little more disillusioned, with the original optimism and hope that a solution could be reached fading. As time passed with repeated attempts to raise their concerns being unsuccessful, these participants began to take the view that they were simply being placated – that is, being told what their managers thought they wanted to hear rather than being taken seriously.

I had gone back to my manager quite a number of times, which really wasn’t any help. I really felt like she understood what I was talking about and what I was saying. She really made me feel like she did understand and that it [issue] was a problem that we were going to have to deal with it, but nothing ever happened  

(W18)

On some occasions the placating responses took the form of a type of counselling session where the participant was encouraged to adapt and accept the matters that had concerned them. Participants reported being counselled that they could come to accept a situation; it was simply a matter of time.

Well, I have talked to the NUM [nurse unit manager]… you know, and… she said that those people are like that and ‘you will get over this with time’  

(B5)

Equivocal avoidance: ‘you don’t know what’s going to happen’

The equivocal avoidant response was evident when complaints and concerns were met with ambivalence or ambiguous responses. Where the placating response created an initial cause for optimism, the equivocal response was one in which there was a perception that the response was evasive or ambivalent.

What was interesting is what was done with nurses’ reports [of bullying]. Unfortunately, the person [manager] said… ‘well I just file them'.
Don’t you do anything about it? ’No, I just file them’ (B4)

This lack of decisive response was experienced as perplexing to participants, who had believed that in raising concerns with managers they were acting in accordance with professional obligations, and within clinical and organisational protocols.

... I’ve addressed it [clinical problem] with the NUM, twice, put in formal complaints and I’ve taken that over to the DON. Nothing’s happened. It really annoys me because you think, well they tell you that you should be taking these things further but nothing happens. Um, nuh, and you just think why, why bother, why bother (B9)

The failure to appropriately acknowledge concerns raised by nurses was seen as evidence of equivocal leader behaviour. This behaviour was noted and commented on, even in managers that were regarded with some fondness and affection.

There were complaints. There were complaints to the NUM, but I think the NUM used to feel a bit intimidated by her as well. So there would never be anything followed up. I think it was easier just to ignore it. I think maybe she didn’t want to believe it. She always I think she was always pos-, tried to be a positive person. She was a lovely NUM and, um, or is a lovely NUM, she’s out of the Department for a little while now but she is a lovely person, but I think it was just too easy to ignore it because it would mean probably having to deal with it. She didn’t want to have to deal with it (B12)

Many health-care organizations undergo habitual and repeated organizational change. This can involve frequent changes of managers, and the appointment of managers to acting positions. In these situations, where managers seemed to be simply disinterested and evasive, participants were of the opinion that some of these leaders had a lack of commitment to the workplace.

I feel that if we had strong leaders in this division sort of, in one place for a number of years, that would have certainly helped stop the bullying occurring. I think it’s very hard when everyone is in acting positions... I think in the past we’ve had Chief Executive Officers using the position as a stepping stone to go somewhere else. We’ve got a person in there as the Director XX, looking out for her own profile to go somewhere else. She doesn’t seem to be doing anything about the bullying and about other things that are coming up, she really doesn’t. She tends to whitewash any responsibilities to go away without doing anything about it (B3)

Some leaders adopted a ‘wait-and-see’ attitude, requiring further episodes of suboptimal clinical practice before any action would be taken. Aside from the equivocal nature of this response, it could also indicate the leaders themselves were anxious or nervous about raising concerns higher up the managerial ladder because to do so could potentially expose them as being inadequate. Participant B11 arranged a meeting with her manager to raise some matters of concern. The managerial response comprised, ’let me know if it happens again’.

Ongoing delay and the postponement of probable effective action was another way that these avoidant leaders were able to defer and neutralize potentially useful actions and render them ineffective.

She keeps saying oh we’re going to have a meeting – a fact-finding meeting – but they never have the meetings. So you’re sort of on tenterhooks all the time – you don’t know what’s going to happen (W3)

Failure to establish the full facts of a situation meant that further investigative or corrective action could be delayed indefinitely. In addition to delaying measures such as meetings that could help reveal the full facts of a situation, the endless postponements meant that participants remained in a state of anticipatory apprehension and unease as described by participant W3 above.

Hostile avoidance: ’then it got out of control’

Although they themselves viewed their complaints as being expressions of genuine concern about a matter they perceived as unethical, wrong or dangerous, participants who experienced a hostile response described a sense that their actions were construed to have malicious intents. This positioning effectively reframed their actions and meant they were perceived as being unsupportive and treacherous to their managers. Perhaps in response to this, managerial threats and counterattacks were commonly described among the hostile responses to complaints. W3 raised her concerns about a patient care issue to her NUM. Her concerns were dismissed by the NUM, so W3, on advice, then acted in accordance with her organizational communication line and spoke to the deputy director of nursing in charge of the area.
...I spoke to the deputy director of nursing [about concerns] and then it got out of control... I got a letter saying that I had accused her [the NUM] of being negligent, which I never did. I never said she was negligent... Then after that I was sort of given the warning that, you know, I was doing the wrong thing and that I had no right to do this. Then she started saying – the NUM started saying that I was canvassing against her and undermining her... (W3)

As with the case of participant W3 above, who was subjected to a range of counter-accusations, several other participants also reported being subjected to retaliatory action for raising concerns. These took the form of counter-complaints, accusations or allegations directed against them.

Some participants reported the hostile acts of their leaders being taken up by others, paving the way for a flow-on effect that became established throughout the work environment. This meant the informants themselves came to be positioned as being the problem rather than the issue they had attempted to raise in the first place. Once matters got to this point, it was as if the original issue of concern had never occurred and did not exist. Instead the participants were themselves positioned as 'problems' who needed to be 'managed'. This positioning then justified the initiation of various measures designed to restore and maintain the organizational status quo.

'I went and saw my boss who assured me that by the time I come back from holidays things would be sorted out and I could come to her... On my first day back from holidays I got called into [manager's] office. Now her words, as I remember them, were I see you've had a good holiday and your head space is now in the right area. Before you went on holidays we feel that you were slightly stressed and your head space wasn't in the correct area and now we can see that it is. However, we'd like to keep it that way for you so we're moving you out of the ward'... (W7)

Once becoming the recipient of managerial or collegial aggression and hostility, participants found it very difficult to turn back the clock to the previous friendly or less hostile state.

Discussion

Few studies have explored in any detail counter-productive styles of nursing leadership and little has been written about the nature of avoidant leader behaviours, their impact upon employees and the potential risks created for the public. Attention in the nursing literature has largely focused upon the positive aspects of executive level leadership styles while overlooking forms of leadership that foster negative outcomes. As a consequence, little is known about avoidant nurse leader behaviours or the individual and organizational factors that might influence leaders to employ this type of response. This paper drew on two qualitative studies to generate new knowledge into various ways avoidant leadership has been enacted in the current clinical environment.

Contemporary leadership theorizing suggests leadership occurs across a spectrum of styles (Daly et al. 2004), with leaders engaging in various forms of leadership reflecting their self-efficacy (Hannah et al. 2008) and the situational context. Avoidant leadership has largely been characterized as laissez-faire or passive (Bass & Avolio 1994) and considered to be enacted through ignorance or limited skills. Our findings highlight additional features of avoidant leadership. On the surface avoidant leadership may appear to be passive or of harmless intent. However, our findings reveal it to be a process that can mask a form of repeated harmful behaviour that can suppress dissent or avoid bringing attention to matters of concern. Our findings reveal the ways in which avoidant nurse leader responses can erode the ethical character of the workplace and undermine the perceptions held by nurses as to the trustworthiness of their employer.

A range of processes for reporting sentinel events and near misses have been implemented in health-care organizations. These systems have been modelled upon those used in aviation and military contexts and are founded upon the premise that organizations should learn from errors and failures (Singer et al. 2008). There are, however, powerful disincentives for reporting within organizations. The climate or culture within an organization can greatly influence the success or failure of safety systems. Factors such as scepticism, lack of trust and fear of reprisal have been identified to erode the capacity of staff to report concerns (Barach 2000). Nurse leaders are central to providing the guidance necessary to ensure the quality of service delivery and facilitating safe and productive workplace relationships. At both the executive and nursing-unit level leadership plays an important role in fostering trust (Edmondson 2004). Research confirms that trust in unit managers bolsters the ability of nurses to systematically pursue changes in their work practices and ensure patient safety (Vogus & Sutcliffe 2007). Trust-enhancing
behaviours from leaders include consistency, follow-up, listening, mutual respect and honesty (Zauderer 2002).

While trust in leaders is a keystone to the success of organizations learning from untoward incidents, developing trust can be a complex and problematic process (Firth-Cozens 2004). When an employee places trust in their leaders, as did the nurses in our studies by reporting their concerns about wrongdoing, they make themselves vulnerable to the subsequent behaviours and actions of their manager that are beyond their control.

It has been proposed that this acceptance of vulnerability is a characteristic of trust which is based on positive expectations of the intentions and behaviours of those in whom the trust has been placed (Rousseau et al. 1998). The narratives presented here illustrate the trust and positive expectations nurses held about their nurse leaders and employing health-care organizations, and how the breach of trust enacted through avoidant leader behaviours had serious implications for these individual nurses. By placing trust in avoidant leaders, nurses inadvertently placed themselves in a position of potential further personal risk.

When problems occur, organizations can learn from them, alternatively they may ignore or cover-up mistakes and errors (Singer et al. 2008). The narratives of our respondents draw attention to the way in which hostile avoidant leader behaviours may be enacted to protect organizational interests, or be employed strategically in certain situations to protect the interests of others within the organization. In these types of instances, by raising concern about perceived wrongdoing, nurses in our study may have been viewed as engaging in actions that were counter-productive or not in the best interests of the organization (Johnstone 2004). This type of culture has been attributed to the unacceptably high rates of errors in the delivery of health care (Institute of Medicine 2000). Rather than framing avoidant leadership behaviour as relatively harmless, we suggest it should instead be viewed as a serious concern in light of its capacity to erode trust within organizations and disempower those who raise concerns.

The climate of health-care organizations, characterized by frequent restructures, continual change and an increasing focus upon fiscal efficiency, may form a counter-current in which enacting forms of positive leadership becomes problematic. The logic of modern managerialism creates a paradox for nurse leaders, one in which they are accountable to sustain both efficiency and caring (Jackson & Borbasi 2009). Little is known about the emotional labour involved in leading in this context, or how this climate may influence the capacity to enact various leadership styles. It is feasible that avoidance may become a survival strategy, employed by leaders in the face of increasing demands and diminishing resources, that creates emotional dissonance and depersonalization (Gardner et al. 2009). Similarly, informally constituted structures of legitimacy within organizations may create pressures to engage in or tolerate avoidant behaviours that serve to protect organizational interests (Gordon et al. 2009). As a result, leaders may ‘fall in line’ with prevailing organizational norms and, over time, may even begin to rationalize avoidance, regardless of the consequences, as a routine or acceptable feature of managing within this context.

When concerns related to health-care delivery and patient safety are ignored, the literature suggests that nurses can experience moral distress because of their inability to effectively advocate for their patients and therefore ensure the provision of ethical care (Erlen 2001, McCarthy & Deady 2008, Schluter et al. 2008, Jackson et al. 2010a,b). Furthermore, nurses have been described as ‘the canaries down the mine or the frogs in the health-care ecosystem who provide the first alerts and early warning signals that all is not well’ (Darbyshire 2011). Disempowered, nurses may give up raising concerns, or alternatively leave the organisation or the profession (Austin et al. 2003).

Limitations

In presenting these findings, we acknowledge that we do not have the perspectives of the leaders themselves. The nurse leaders may have offered alternative insights and have provided understandings of the machinations of organizations that would inform expectations about when a change or response might occur. In addition, it should be pointed out that the data reflected extreme situations and our informants had experienced significant events that may have affected their careers and lives in an on-going way, and may have influenced the way that events were recalled (e.g. the interpretation of responses of the leaders may appear to be defensive).

Conclusion and implications for nursing management

Nurses are urged, and in some locations legally mandated, to report wrongdoing. Though there may be an assumption that simply reporting a problem to a manager will result in positive action, this paper has revealed that managers may not act responsively, efficaciously or decisively to effect positive change.
following reports. Through secondary analysis of two existing sets of data, we have been able to shed new light on avoidant leader behaviours demonstrated in response to concerns raised by nurses. In seeking to explore organizational wrongdoing in two contexts, nurses experiences of raising concerns were made visible, and in particular their attempts to engage in appropriate responses from their nurse leaders.

It is feasible that lines of communication and accountability within organizations may themselves hamper or obfuscate leadership actions and responses. This may limit communication and delay the timeliness of responses, creating among followers a perception that their leader is shying away from, or abstaining from active leadership. Given the negative effect avoidant leader responses can have upon the perceptions and beliefs of employees we recommend that organizations ensure that all nurse leaders are aware of how best to respond to concerns of wrongdoing, to be supported in doing so, and that mechanisms are created to ensure timely feedback is provided about the actions taken. The design of reporting systems should be considered from the perspective of whether they provide the level of transparency required to sustain trusting relationships and the capacity to learn from even difficult experiences without shaming (Firth-Cozens 2004). Consideration should also be given to developing systems that incorporate leadership accountability as a key to fostering safe organisational cultures (Sammer et al. 2010).

In highlighting the impacts of avoidant styles of leadership we seek to broaden the debate on nursing leadership. While avoidant leadership may seem relatively harmless, it has the potential to seriously undermine health-care safety and service provision. Further work needs to be undertaken to better understand this leadership style. This is important to ensure that organizations do not elevate to management positions individuals who lack the capability to respond appropriately and who, instead, respond with avoidance when concerns and risks are raised. In highlighting the lack of substantive information on avoidant leadership we have also raised the need for more robust theorizing and research on nursing leadership and leadership practice, as understanding these factors is fundamental to ensuring a viable nursing leadership for the future.

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Ethical approval

Ethical Approval was obtained from the relevant Institute Ethics Committee.

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