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Discourse of 'transformational leadership' in infection control

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ABSTRACT The article explores the impact of the 'transformational leadership' style in the role of modern matron with regards to infection control practices. Policy and guidance on the modern matron role suggest that it is distinctive in its combination of management and clinical components, and in its reliance on transformational leadership. Senior nurses are therefore expected to motivate staff by creating high expectations, modelling appropriate behaviour, and providing personal attention to followers by giving respect and responsibility. In this article, we draw on policy documents and interview data to explore the potential impact of this new management style on infection control practices. Combining the techniques of discourse analysis and corpus linguistics, we identify examples where matrons appear to disassociate themselves from the role of 'an empowered manager' who has control over human and financial resources to resolve problems in infection control efficiently.

KEYWORDS *infection control; modern matron; transformational leadership*

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Introduction

Since the early 1990s, methicillin-resistant Staphylococcus aureus (MRSA) infections have become widespread in most UK hospitals (Jeyaratnam et al., 2006). The reasons for the wide spread are not clear, but contributing

factors may include the emergence of the epidemic strains EMRSA-15 and EMRSA-16; failure to introduce and maintain suitable infection control procedures, particularly handwashing; increases in movement of patients, visitors and staff; inadequate ward staffing levels; inadequate isolation facilities; high bed occupancy rates and overall poor hospital cleanliness (Enright, 2005; see also Grundmann et al., 2002 for an overview).

'Modern matrons' were created (DH, 2001, 2002a, 2002b, 2003a, 2003b, 2004a, 2004b) in response to public demand for an authoritative figure who would not only provide clinical leadership, but who would also be easily identifiable, have close contact with patients and ensure delivery of care to the highest standards – ensuring regular monitoring of ward cleanliness and prevention of hospital-acquired infection (McDonald, 2004). Modern matrons should be able to exercise their authority through collaboration with medical and other multidisciplinary colleagues. As it is uncertain how the authoritative management style of matrons in the past fits into today's nursing and healthcare culture and the focus on empowerment (Oughtibridge, 2003), it was suggested that the role could be seen as enabling, rather than strictly authoritarian, using transformational leadership styles.

In this article we will identify problems that challenge this model of the modern matron and link them to possible problems in infection control – in other words, look at loopholes left open by gaps between aspirations and realities through which infection can creep in. Drawing on policy documents and interview data, and using Goffman's (1961) concept of role analysis as an analytical framework, this article explores which aspects of the modern matron role are 'embraced' by senior nurses and which are 'distanced from', as well as situations where they experience 'role diffusion'. We aim to explore the impact of the 'transformational leadership' style in the role of modern matron with regards to infection control practices, and to highlight experiences of modern matrons that can instruct future guidance for an increased involvement of matrons in infection control.

Background: senior nurses as managers and 'transformational leaders'

A recurring theme in the literature on the senior nurse role is the difficulty of balancing clinical, administrative and staff management responsibilities while demonstrating a strong lead at the same time (Strong and Robinson, 1990; Traynor, 1999; Rivett, 2007). Below we provide a short outline of the historical development of managerial and clinical responsibilities of senior nurses, from the introduction of managerial components of the role to the recent reinvention of nurses as managers conforming to the 'transformational leadership' style.

The first attempt to modernize and improve the career structure of nursing in an increasingly complex health service took place in the 1960s

with the introduction of the new posts of Nursing Officers suggested in the *Salmon Report* (DHSS, 1966). The Report officially recognized nurses as managers while abolishing the traditional matron role (Rivett, 2007). This was further enhanced in the 1974 reorganization of the NHS with the introduction of the principle of 'consensus management' where nurses were given a statutory right to be included in senior management teams at district and area health authority levels (Ackroyd, 1996; Bolton, 2005). The increase in managerial responsibilities, however, distanced senior nurses from the wards, which, as Rivett (2007) points out in his history of the NHS, had its implications for infection control:

> Nursing practice no longer resembles the systems current when the NHS was introduced. Then the ward sister had wide responsibilities, which included domestic staff and perhaps a ward maid. With the passage of time responsibility for the cleanliness of the ward, or the patients' food, was taken from her. Few could now recall the level of personal care commonplace in the fifties and sixties.

About a decade later, the *Griffiths Report* (DHSS, 1983) introduced the 'general management' structure into the NHS, and control has been transferred from medical professionals to financial managers with the emphasis on financial efficiency and the delivery of a quality service to the consumer (Strong and Robinson, 1990; Bolton, 2003). Since then, senior nurses have not had significant authority over budgetary and financial matters.

In response to the numerous complaints about dirty and ineffective hospitals the British government introduced 'modern matron' posts in 2001 (DH, 2001). Around this time, the Royal College of Nursing (RCN) took up the call for nurses to become more involved in management, with the introduction of their transformational leadership programme. The concept of 'transformational leadership' (Bass and Avolio, 1993) concerns 'engendering higher levels of motivation and commitment among followers, with an emphasis on generating a vision for the organisation or team' (RCN, 2004: 13). The effective leader has the skill to motivate, inspire, stimulate and facilitate others (Kouzes and Posner, 1997). To this extent, personal skill is likely to be more important than the position in the organization's management hierarchy. As a result, in contrast to the early portrayals of senior nurses as domineering figures in charge of a ward and leading a group of nurses, the RCN adaptation of the modern role sees senior nurses as 'facilitators' and 'co-ordinators' of care, with a larger portfolio of tasks and responsibilities which extend to covering budgetary matters, quality measures and human resource management issues.

Despite problems with the application of the 'trasformational leadership' model in other public sector organizations (Currie et al., 2005) and critical comments that management in the NHS now bears 'no resemblance to the consensual management arrangements in which matrons operated

in the 1970s' (Bolton, 2003: 123), evidence is said to accumulate for the effectiveness of transformational leadership skills in fostering performance in healthcare (e.g. Clegg, 2000). In this study we want to explore the impact of transformational leadership in infection control – the area of healthcare in which modern matrons are meant to instigate crucial changes. Several studies critically evaluated the role of modern matrons and pointed out role ambiguities (Hewison, 2001; Moiden, 2002; Bolton, 2003, 2005) including a detailed report submitted to the Department of Health by the RCN (RCN, 2004), but as yet little research has looked at the potential impact of the new management style on infection control practices.

Data

Two sets of texts were collected to compare and contrast the role of the modern matron prescribed in policies with realities on the ground: a corpus of Department of Health documents on modern matrons (listed at the end of the References section); and a corpus of semi-structured interviews conducted in a large healthcare trust in the East Midlands. The first set is made up of 10 documents issued between 2001 and 2006 dealing with the introduction of modern matrons and their involvement in infection control practices (54,449 words). The second set of texts is comprised of 10 anonymized interview transcripts with modern matrons (51,016 words). All participants but one had been in post as a modern matron for over a year since the role was introduced within the trust.

The interview structure was designed to be as informal and open-ended as possible. Below are some examples of the questions used as prompts:

- Please describe your role in the hospital.
- What are the main challenges that you face?
- Could you describe your typical day?
- Has MRSA affected your work in any way?
- A number of reasons have been mentioned to explain the rise in MRSA rates. What is your opinion on this?

Ethical considerations

The study was approved by the Local Research Ethics Committees for the whole trust. Written consent was obtained from all senior nurses after they had been given information indicating the purpose of the study and information about how the data would be used. Assurances of anonymity and confidentiality were given. Participants were aware that they could cease recording at any stage.

Methods and conceptual framework

Methods of corpus linguistics were used to identify main themes emerging in the corpus of policies and in the corpus of interviews. Computational tools such as concordances, word and keyword lists developed for processing large volumes of real language data (Sinclair, 1991) can be a valuable supplement both for quantitative and qualitative studies of discourse. Although corpus linguistic methods may be less known to social scientists than techniques of computer-assisted qualitative data analysis (CAQDAS),[1] the benefits of corpus work are quickly being recognized by medical researchers and professionals and recently there has been a variety of insightful corpus studies into the domain of health communication and health care discourse (Skelton and Hobbs, 1999; Adolphs et al., 2004, Brown et al., 2006; Seale, 2006).

One of the strengths of corpus linguistics lies in the availability of a large sample of instances of use, which form the basis for an analysis of emerging patterns (Hamilton et al., 2007). A set of concordance lines presents instances of a word or phrase usually in the centre, with words that come before and after it to the left and right and provide a quick access to a number of contexts where a selected word is used. Frequency-sorted word lists represent another standard method for exploiting corpora. They allow precise quantification of the most commonly used words in a given communicative context and are commonly employed to establish the 'aboutness' of individual texts and whole corpora. The list can be arranged alphabetically or in frequency order. The study of frequently used words through word lists and subsequent examination of their contexts through concordances can therefore serve as a 'diagnostic' tool for revealing various trends and patterns (Leech, 1991; Adolphs et al., 2004) that provide evidence for the constituent potential of language in theories of society and culture.

The method used in our study is suited to the conjoint qualitative and quantitative analysis of relatively large bodies of text and represents an alternative to the 'code and retrieval' approach used in much thematic analysis of qualitative materials (Seale, 2005). First, word frequencies were calculated with the help of WordSmith software (Scott, 1999). The lists were lemmatized[2] and manually stripped of grammatical words.[3] Concordances were then generated for high and medium frequency words to explore their contexts of use. After the examination of their concordances, frequent words were grouped according to semantic criteria (for example, words such as *talk*, *speak* and *say* were assigned to a subset of 'communication'). This allowed us to retrieve quickly lexis employed to prescribe responsibilities of the modern matron in the policies on the one hand and words used by modern matrons themselves to describe their visions of their role and responsibilities on the other hand. The method, therefore, enables an

interpretive approach, as its purpose is to identify 'meaningful constellations of words' (Seale, 2006: 349) that may be indicative of emerging analytic themes.

The concept of 'role analysis' introduced by the sociologist Erving Goffman was chosen for an in-depth study of the main themes identified with the help of the combined computational tools in the matrons' accounts. Goffman's sociological method has been influenced by phenomenology. It borrowed in particular from the work of Alfred Schutz on interactive relations, commonsense understanding via types, and the situational character of relevance. This explains his interest in particular settings, forms of self-maintaining behaviour such as the display of 'focused interaction', conduct in public and public displays of competence.

Goffman's concept of impression management and dramaturgical loyalty (used to refer to performers who are completely committed to the performance at hand) have been widely used to shed light both on individual behaviour and on the image-work done by an organization (e.g. Benoit and Czerwinski, 1997). In the domain of health care discourse, Goffman's framework was employed by Bolton (2005) to study responses to endeavours aimed at the incorporation of health professionals into the management of the British National Health Service (the NHS).

Goffman's (1961: 86; see also Dahrendorf, 1973) account of the role is insightful as it proposes that the focus of study is not the individual but the individual carrying out a 'bundle of obligatory activity' within a system of social action. Each role is recognized as having specific characteristics and there are certain expectations as to how the role will be enacted. Social actors may be involved in more than one situated social system and will, therefore, have several roles and all the obligations of activity.

Goffman does not see actors as passive followers of the dictates of role. Although he recognizes the existence of certain 'constraining obligations' involved in a role, Goffman describes role enactment as an ongoing social process during which individuals continuously make 'creative compromises' (Turner, 1962: 32). An actor can therefore not only 'embrace' a role, that is, completely disappear into the self available in the situation, but also be emotionally detached from the role that is being performed. In this way, they keep 'role distance' (Goffman, 1961).

The concept of role distance provides a sociological means of dealing with one type of divergence between obligation and actual performance. This is especially useful for our study when considering how senior nurses can be both sceptical and enthusiastic in the enactment of the Department of Health allocated role of the modern matron rather than blindly following the 'powerful discourse of enterprise' (du Gay, 1996: 154). As roles cannot only be played, but also 'played at' (Goffman, 1961: 99), in our study of modern matrons' accounts we will pay particular attention to instances where senior nurses appear to 'distance' themselves from their 'co-ordinator of care'/ 'agent for change' role as far as infection control practices are concerned.

Analysis of the policy documents

Throughout the 1990s, healthcare professionals have been bombarded with the language of quality and customer care (Ham, 1997; Bolton, 2003). The recent policies on modern matrons and infection control practices are no exception, only now the focus of attention is on one particular group of caring professionals, variously called clinical nurse managers, modern matrons or senior nurses.

Frequency lists generated for the corpus of policies have revealed several thematic trends in the lexical composition of Department of Health (DH) documents. As can be expected, infection (n = 394) and patients (n = 306) head the list of lexical (as opposed to grammatical, functional) words, followed by other words that one can expect to find in a health care context. Other high frequency lexical items reflect the focus on customer care language in the description of the modern matron role: *lead, standards, cleanliness, authority* and *manage*. Words occurring with medium frequency, such as *enable, skills, power* and *visible* add to the picture of a 'thoroughly modern matron' painted in the policies: a hybrid manager in a complex organization who can provide 'visible assurance that there is an authoritative figure who is clearly "in-charge" of standards and able to intervene where necessary to resolve problems quickly and effectively' (DH, 2001: 8).

The investigation of concordances drawn for the above lexical items revealed a rich rhetoric of 'empowerment' around the modern matron role (Appendix 1.1). The following examples illustrate how the empowerment of modern matrons is relevant for infection control practices:

> Nurses and infection control teams will be involved in drawing up cleaning contracts, and Matrons given authority and power to withhold payment. (DH, 2004: 1)

> Matrons are still rightly seen as the linchpin of standards, and they have the power and authority to lead change and deliver cleaner hospitals. (DH, 2009: 2)

The visibility aspect of the role is consistently stressed throughout the policies (Appendix 1.2). The Health Service Circular on Matrons (DH, 2001), for example, links visibility and accountability to the image of the old-style matron – 'an authoritative figure who is clearly "in-charge" of standards':

> A key element of the policy is to respond to public perceptions that, even where there is clear accountability for quality standards, it is often not obvious to patients. They want visible assurance that there is an authoritative figure who is clearly 'in-charge' of standards and able to intervene where necessary to resolve problems quickly and effectively (DH, 2001: 8).

Ward sisters and unit managers are to be given the 'authority and support they need to resolve clinical issues and to ensure that the basics of care are right' (DH, 2001: 6). In this way, the 'empowerment' of nurses as organizers of care is seen as a route to self-development. In this pursuit of

quality care, matrons are offered involvement in activities usually deemed to be within the remit of departments such as finance or personnel. As the price for this autonomy and empowerment, the modern matron must show initiative, self-reliance and accept responsibility (du Gay, 1996).

This focus on inspirational leadership in policies is expected to appeal to the internalized 'vocabularies of motive' of front-line healthcare professionals who are concerned with the delivery of a quality service (Bolton, 2005). According to Mills (1940), vocabularies are constructed through terminologies of justifications for people's actions (taken from cultural sources), and need to be seen as situated in a given time, place and social group:

> Men discern situations with particular vocabularies and it is in terms of particular vocabularies that they anticipate consequences of conduct. Stable vocabularies of motives link anticipated consequences and specific actions … In a societal situation, implicit in the names for consequences is the social dimension of motives. Through such vocabularies types of social control operate … Institutionally different situations have different vocabularies of motive appropriate to their respective behaviors. (Mills, 1940: 906)

But to what extent do the postholders identify themselves with this role of 'a transformational leader'? In the next section we will study the matrons' accounts to find out how far the rhetoric of 'empowerment' reaches into the day-to-day realities of infection control practices.

Analysis of the interviews: the realities of 'transformational leadership' and infection control

Although not impossible, the micro-analysis of discourse following Goffman's model can be time-consuming when one has a relatively large collection of data at hand. The study of word lists therefore offers a good opportunity to take a preliminary look at the thematic composition of interviews. Transcripts were processed to remove the interviewer's words so that only respondents' words remained and the remaining text was used for quantitative and qualitative analysis.

Frequent lexical words from the words list (see Table 1) were arranged into the following broad semantic groups: 'health care' (*nurse, care, ward, theatre, etc.*); 'organization and administration' (*work, environment, services, manager, responsibility, standards*), 'communication' (*talk, say, tell, discuss, meet*) and 'difficulties' (*issues, need, try, problem, difficult*).

The corpus-assisted identification of the main themes in the interview transcripts allowed us to proceed to a more fine-grained analysis of the interview transcripts. Concordances generated for words from the group 'organization and administration' show that matrons appear to have internalized much of the policy terminology, particularly the vocabulary of

Table 1 **Word frequencies in the corpus of interview transcripts (with a cut-off point of 0.07%)**

Word	*Freq.*	*%*	*Word*	*Freq.*	*%*
KNOW	514	1.81	DAY	68	0.13
THING	358	0.70	SEE	67	0.13
THINK	352	0.69	BED	64	0.13
CAN	292	0.61	TRY	63	0.12
PATIENT	268	0.53	THEATRE	59	0.12
ALL	241	0.47	SERVICE	58	0.11
WARD	237	0.46	PUT	57	0.11
PEOPLE	217	0.43	AROUND	56	0.11
GET	209	0.27	CLEAN	56	0.11
MATRON	194	0.38	DOMESTIC	55	0.11
INFECTION	182	0.36	HEALTH	55	0.11
STAFF	181	0.35	PART	55	0.11
LOT	179	0.35	ENVIRONMENT	54	0.11
WORK	171	0.34	SERVICE	54	0.11
MEAN	161	0.32	NURSING	53	0.10
NURSE	139	0.27	TEAM	53	0.10
CONTROL	130	0.25	WAY	52	0.10
MAKE	115	0.23	TAKE	51	0.10
MRSA	115	0.23	TERM	47	0.09
HOSPITAL	108	0.21	ABLE	46	0.09
HAND	106	0.21	TELL	45	0.09
NEED	106	0.21	MODERN	44	0.09
LOOK	105	0.21	STANDARD	43	0.08
GO	92	0.18	YEAR	43	0.08
COME	88	0.17	CLEANLINESS	42	0.08
WASH	82	0.16	ISSUE	42	0.08
MAY	82	0.16	MEETING	42	0.08
TIME	80	0.16	CARE	40	0.08
CLEAN	79	0.15	WANT	39	0.08
GOOD	79	0.15	DOCTOR	39	0.08
ROLE	79	0.15	HAPPEN	38	0.07
DIFFERENT	76	0.15	JOB	37	0.07
AREA	75	0.15	KIND	37	0.07
DO	74	0.15	PRACTICE	37	0.07
SURE	73	0.14	TRUST	37	0.07
CLINICAL	72	0.14	EVERY	36	0.07
MANAGE	72	0.14	HELP	36	0.07
SAY	71	0.14	MOMENT	36	0.07
AREA	69	0.14	OWN	36	0.07
BIT	68	0.13	GENERAL	36	0.07

'quality care', as they speak about 'clinical leadership' 'care for the environment', 'patient journey', 'patient experience', 'improvement', etc. when describing their role and their involvement in infection control practices:

> It is very much about looking at the service, making sure that you're taking the service forward, that you're an agent for change, that you know the patient is at the centre of what we do. (interview 12)

> And a big part of my role as well is to maintain standards of care so there's lots of innovation, changes in practice, looking at processes … (interview 2)

Some of the matrons appear to be very clear about the 'enabling' aspect of their role, which involves a lot of interpersonal interaction (hence the high frequency of 'talk' and 'tell', 'say', 'meet'): 'And the purpose of the modern matron role is to have a link. This is the person, if you have concerns this is the person' (interview 12).

The high frequency of the verb *work* and the preposition *with* is particularly informing about the networking aspect of the modern matron role: matrons seem to work with a large number of groups such as domestics, HR personnel, nurses, ward managers, infection control staff (see Appendix 2.1). Also, in line with the 'enabling' rather than 'authoritarian' aspect of their leadership, they seem to prefer to 'work with' their staff (nurses and ward managers) rather then simply 'manage' them: 'what I do is work with all the wards on site, so work with the ward managers, give clinical leadership advice, offer support, offer supervision' (interview 19).

The systematic study of concordances generated for frequent words belonging to the group of 'difficulties' helped us to identify examples where matrons appear to disassociate themselves from the role of 'an empowered manager' who has control over human and financial resources to resolve problems efficiently in infection control.

For example, concordances for the verb *need* – one the most frequent words in the corpus (see Table 1), the verb *try* (Appendix 2.2), and the plural form of the noun *issue* (Appendix 2.4) were used as a quick guide to difficulties experienced by modern matrons in the day-to-day enactment of their role. One of the matrons, for example, used *need* to refer to the pressures that result from the conflict between obligations and realities of such a complex negotiated order as a hospital:

> So for instance for one of my areas I need to close twelve beds but I need to do the same level of, we need to do the same level of activity but I potentially need to lose some nurses as well. So we've got to do the same amount of work in less beds with less staff. (interview 9)

The same person then became rather critical about one of the key responsibilities of the modern matron: the idea of the modern matron being a 'liaison' person between different groups, which presupposes her involvement in various meetings: 'And then when you're, when you're

reducing jobs within the sort of workforce change process and within employment law the amount of meetings that have to be then are just sort of phenomenal really' (interview 9).

Another act of 'role distancing' could be observed when a matron referred to the numerous meetings she had to attend as 'the bane of my life' (with a comic sigh). She then continued to explain:

> I mean if you looked at my diary there would be all these meetings and me running around different places in between them trying to actually do the parts of my job that I felt were important like being visible, talking to the staff on the shop floor, dealing with complaints. (interview 21)

The high frequency of *lot* (in the word combination *lots of/a lot of*) alerted us to the multiplicity of tasks that modern matrons are expected to perform on the everyday basis. Words following this combination, such as *managing, e-mails, audits, constraints,* etc. (highlighted in italic in the concordance, Appendix 2.3) denote a number of things that may receive precedence over infection control related issues.

> I would do lots of HR type issues, lots and lots of those kind of things, I do sickness interviews, recruitment, general sort of disciplinary type, performance management kind of things. I'm very involved at the moment in meetings around workforce change. I meet regularly with my business manager, my divisional nurse, my finance link person. (interview 12)

Modern matrons also seem to be pulled in different directions because of multiple expectations about their role:

> I mean people still think Hatty Jacques is modern matron and that it is. And there is an expectation from users and carers that I will appear in a uniform and I will be you know bossing people around which I do do, but I don't wear a uniform. So there are quite a lot of things, there's quite a lot of confusion about that role. (interview 21)

The examination of the concordances of 'try/trying' illustrated the lack of real power to bring about changes in practices and procedures. The following quotation betrays a certain deal of scepticism about the responsibilities of the modern matron with regard to patient care and infection control:

> And I think that is down to policy, locally and nationally really in terms of cuts, savings, making people responsible for things and accountable for things that they actually have no jurisdiction over. It's just bonkers really you know. So like I mean they're the key things and it's just working it's just working away trying to, trying to do the right thing really. (interview 9)

Further examination of the concordances reveal that management and policy speak is something that senior nurses as 'care workers' would prefer to distance themselves from: 'We're all so busy trying to achieve somebody else's targets so we don't focus on our own area of practice and make it the best it can be' (interview 21).

Changes to hospital services in the 1990s led to an 'internal market' style in the health services (Ham, 1997). This had resulted in control being taken away from clinical nurses and relocated in centralized areas of the organization. Modern matrons were given power to withhold payment for contracted cleaning, but this does not seem to have significantly influenced their sense of 'empowerment' in dealing with cleaners: 'I do think that we should have more, more control over the domestic services and what, and be involved in decision making when they reduce their numbers or have sickness' (interview 12).

This type of 'empowerment' might therefore have been more symbolic than real:

> I'd like to be given a fair chance to deliver what's expected of me and that's to deliver a good quality patient service, reducing the risks to patients, including infection. And whilst I'm being told that I can't recruit to nursing vacancies and I'm having to cut beds and I'm having to reduce staff and I know that all the other areas are and I have actually no responsibility, they tell me I have responsibility for the cleanliness in my areas but I don't have any input over the staff that provide that service. (interview 9)

The same matron also pointed out what can be called her 'powerlessness' when describing her experience of trying to discuss issues around cleaning. In this case, communication skills – one of the attributes of the transformational leadership style – seem to have little effect:

> He didn't feel that he could answer those questions and thought I should talk to this person, so I talked to that person who felt it should be that person. Which again is a bit like the cleaning thing, you know I can talk to the domestics and say look guys can you just make sure that you give the side rooms a good clean out because they're you know. But then their boss can come along and say right you've done that bit now, you need to move to another area. (interview 9)

Another barrier to achieving improvements in infection control and patient services was raised in the interviews. This was the question of the relationship with other professions. Improvement of infection control practices such as handwashing and environmental cleanliness requires the modern matron to challenge ways of inter-professional working and organizational culture:

> I don't have control over medical staff and that can be challenging sometimes … And it's quite difficult to change habits and perceptions and ideas when it's not my staff. (interview 12)

> So you've got patients and visitors coming to the ward using the gel appropriately, the staff on the ward using the gel appropriately and I'm not an anti doctor person but doctors seem immune to passing on infection. (interview 4)

Therefore it looks like that, in practice, there needs to be a change in how other professions see the role of the modern matron to allow them

successfully to challenge practice and achieve lower rates of cross-infection on the ground.

The visibility aspect of the modern matron role is particularly hard to maintain and represents another aspect of the modern matron role which indicates 'role diffusion' and stands in the way of the complete 'role embracement' by senior nurses. The diffusion of role takes place both hierarchically as well as geographically. Some senior nurses are expected to co-ordinate a number of wards across an extensive area:

> I cover five wards across the north of the county, so I cover wards that are located right in the north of the county and it means that 40 odd miles between each hospital ward that I cover so that makes my job incredibly difficult in the sense that the visibility aspect of it is almost impossible to maintain. (interview 21)

For others, the hierarchical spread of the role and proliferation of tasks seem to pose a more serious problem as far as the visibility is concerned. With so many responsibilities and different priorities to juggle, the modern matron simply does not have time to be on wards to ensure 'visible presence', which runs contrary to the generalized assertion that 'Matron's Charter Nurses know what works on the wards' (Matron's Charter). As a result, they have to spend most of their time in the office going through paperwork and overseeing the cleanliness of wards through audits.

> I think, I believe the ward sister is responsible for maintaining the levels of cleanliness etc. on the ward. I will come in if the audits show that targets aren't being met etc. But because I'm not on the ward 24 hours a day I see that clearly as the ward sister's role. But I'm ultimately responsible. … I don't think it's particularly useful, *certainly as it works at the moment*, for me to come in when there's a problem. (interview 4, emphasis added)

Diffusion of the role is also evident when matrons talk about their attempts to conform to the expectations and act as a liaison person. On the one hand the matron is supposed to be the 'visible' link between various organizational levels, but on the other this visibility is diluted in so far as it is impossible to be (seen) in various places at once, be it physically or metaphorically (up/down/between):

> I'm perhaps less a clinician and more, and I'm not, and I wouldn't call myself a manager but I sit uncomfortably somewhere between the two. … I mean I try to be somewhere between what I call up there which is management and kind of organizational structures and the shop floor, so I see myself as an in-between person. … So I believe that I've taken on that role as a senior clinician if you like within the teams although I can't produce I believe a lot of the expectations of staff. Everybody has got different expectations and I just have to do what I can. (interview 21)

The matrons' accounts cited above suggest that the impact of the modern matron could have been greater if the 'aspirational' aspects of the role were not as far removed from 'reality' as they seem to be – a gap that should

be closely monitored in order not to let failings, especially with regard to infection control, creep in. As one of the matrons summarized: ‘So I think it’s made an impact and I think it’s a positive impact but I think the impact could be greater if the infrastructure had been sorted out accordingly really’ (interview 9).

Discussion

The policies call for new ways of working and not a return to old ways of managing staff. One way to move beyond the ‘old’-style matron role is seen as taking a clinical lead. Here the authority of the modern matron and expertise appear to derive not so much from previous nursing expertise but from transferable skills, such as clinical judgement, observation and communication skills – all attributes of ‘transformational leader’.

The rationale behind the introduction of the modern matrons was to have a person focused on patient care and issues around cleanliness, just like ‘in the old days’. However, the ‘modernization’ of the matron seems to overshadow these aspects of heathcare service, as present-day matrons are expected to be primarily involved in the continuous quality improvement, appraisal, and target setting. As Bolton (2005: 8) observes, while relying on ‘the well established matriarchal figure of the senior nurse, the role of modern matron also reinvents senior nurses as enterprising “co-ordinators of care”’.

Data collected from modern matrons indicate that they adopt a pragmatic approach to their responsibilities. Some aspects of their role are welcomed and senior nurses are enthusiastic in their responses to various policy initiatives. However, when it comes to such issues of infection control as maintaining cleanliness on the ward and encouraging handwashing by doctors and visitors, the same matrons show a certain degree of ‘role distancing’. They seem to display a critical appreciation that beyond the vision of matrons as empowered ‘agents for change’ are tight budgetary controls and performance measures and targets.

Senior nurses are keen to disassociate themselves from the title of ‘authority figure’ when it comes to resolving problems regarding infection control, such as dealing with contracted cleaners, hiring extra nursing staff (for example, when they are needed for barrier nursing) and ‘empowering’ doctors with knowledge about infection control issues such as handwashing to prevent cross-infection. Negotiating authority for action in new modern matron roles requires acknowledgement from other professionals and occupations, and it appears that acknowledgement of authority is negotiated predominantly from medicine (Woods, 2000; Allan and Smith, 2005). In these situations, modern matrons tend to see their role as that of a middle/link person restricted by various organizational and financial constraints.

This linking function can, however, become a problem in itself when it comes into conflict with the ‘visibility’ function of the role and therefore lead

to 'role diffusion' and uncertainty, as the modern matron has to negotiate work across both hierarchical as well as geographical boundaries. A similar problem arises from the conflict between increasing administrative tasks (which make the matron invisible) and wanting to achieve clinical leadership and being accessible to patients.

Conclusions

The role of the modern matron was first described in the NHS Plan (DH, 2000: 89) as 'someone to get things done, someone patient focused'. The hope was that nurse managers would be able to capitalize on the current popularity and visibility of the term 'matron' to ensure better patient care and improved infection control practices. This is the expressed purpose of HSC 2001/010. Three years later, the evaluation of the modern matron role draws attention to the 'fragile sense of authority' (RCN, 2004: 158) experienced by the postholders, but the implications for cleanliness and infection control remained unexplored.

Although the findings from our data suggest that the modern matron appears to fulfil many of her role requirements and provide a level of support for clinical nurses it is still problematic as far as infection control is concerned. The modern matrons interviewed for our study were aware that their role as set out in the Department of Health HSC 2001/010 required them to undertake responsibility for co-ordinating practices in infection control but were realistic about how effective they could be unless the system was changed.

The traditional matron was clearly in charge of the ecology of cleanliness, maintaining rigid line management of personnel such as the assistant matron, housekeeping sister, home sister, ward sisters and ultimately the 'scrubbers' who cleaned the wards, corridors and staircases. This traditional strong leadership that came to an end with the *Salmon Report* (DHSS, 1966) has not been revisited in the modern matron. A diffusion of power is evident in a clear shift from the authoritarian old-style matron to the newer and more thoroughly mundane modern matron. Despite similarities at a rhetorical level, the reality is that the modern matron does not achieve the status of a 'powerful figurehead', who would be 'highly visible' on the ward and who would have time and resources to resolve issues effectively in infection control.

This is why, when asked whether their department liaises with matrons, a clinical microbiologist working at the same trust[4] said: 'We don't have any, I think they're called clinical nurse managers'. They went on:

> they seem to spend their time doing management as opposed to matroning. So if you, if the Government think that they're, the modern matrons have brought back a sister in charge of cleanliness and hygiene they can, well it certainly hasn't worked locally. The clinical nurse managers are concerned with waiting lists and throughput of patients and are not actually doing matron type work.

This study has described cases of difficulty in fulfilling leadership requirements because of organizational barriers to empowerment despite arguments to the contrary. The modern matron does not seem to achieve the status of 'agent for change' as far as infection control is concerned. Some positional authority is important for building professional credibility, and, subsequently, for introducing and sustaining new initiatives in infection control. As Millward and Bryan (2005: 25) point out in their report on the concept of leadership in healthcare, a clinical leader 'should have some authority over financial and other resources, as well as some ability to upwardly influence health care policy'. Unless a significant budgetary responsibility is made part of the modern matron role, personal skills (communication, problem solving) alone may not be sufficient to sustain it (Hewison, 2001; Moiden, 2002) and may not lead to achieving control over infection, which was the initial trigger for instituting the role of the modern matron. Achieving a balance between managerial and clinical duties, interpersonal skill, and authority over financial resources remains a major challenge in this crucially important area of healthcare.

Appendix 1: Concordances from the corpus of policy documents

1.1 Concordances of empower

N	Concordance
1	n to ensure that NHS employers empower appropriately qualified
2	frontline. They are helping to empower nurses and are ensuring
3	e and to inspire, motivate and empower others; the Chief Nursi
4	their leadership skills and to empower other members of their
5	by example and to motivate and empower others. The guidance al
6	and essential aspects of care empower nurses to take on a wi
7	Matrons in the NHS · empower nurses - by enabling m
8	eading by example so that they empower nurses to strive for h
9	heir own environment and being empowered to do something about
10	ogether to find solutions...by empowering ward managers and si
11	standards of clinical care and empowering nurses to take on a
12	iven nurses some authority and empowerment and given our patie

1.2 Concordances of visible

N	Concordance
1	NHS Trust. "Matrons are very visible just by the uniform w
2	ge nurses who provide strong, visible clinical leadership. T
3	ell as cleanliness, should be visible and reliable. Often, p
4	es designed to secure strong, visible clinical leadership ap
5	ng standards and being highly visible to staff, patients and
6	if strong leadership was more visible and closer to the pat
7	ership on wards and be highly visible and accessible to pati

(Appendix 1 continued)

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 8  ernisation agenda ... [and] a visible and accessible figure
 9  of standards and being highly visible to staff, patients and
10  thcare associated infection a visible and unambiguous indica
11  bvious to patients. They want visible assurance that there i
12  a group of wards and a highly visible, accessible and author
13  ce; ensuring that matrons are visible, easily identifiable b
14  standards of care providing a visible, accessible and author
15  o that the benefits of highly visible, accessible and author
16  s by providing someone who is visible, works on the wards a
17  me to "walk the floor" and be visible.    • Trusts to provi
```

Appendix 2: Concordances from the corpus of interviews

2. 1 Concordances of work with

```
N                          Concordance
 7  ork with two different groups, I work with the main hospital clea
 8  doctor and also I do a lot of, I work closely with the Director o
 9  hatÆs very interesting because I work with two different groups,
10  upport, offer supervision.  So I work with them but I donÆt line
11   at both of the campuses.  And I work very closely with the infec
12  e any of the staff, what I do is work with all the wards on site,
13  of the staff but what I do do is work with the staff very closely
14  tal health what we try and do is work with the patient at their r
15   is what we were trying to do is work with people in terms of you
16  a lot of work, do quite a lot of work with the media    I Oh righ
17  y week and theyÆve done a lot of work with MRSA and with publicis
18  k with all the wards on site, so work with the ward managers, giv
19   they probably needed to do some work with their infection control
20  as been looked at so IÆm able to work with the ward staff to help
21  ction and that I do my utmost to work with the staff to encourage
22   And I think certainly trying to work with the environment care c
23  s better than cure and how do we work with the clients in terms o
24  of that is about actually how we work with staff and users and ca
```

2.2 Concordances of trying

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N                          Concordance
 1  think when we were actually trying to talk about it the
 2  ing people off the beds and trying to restrict visiting
 3  king it's just working away trying to, trying to do the
 4  ne of the things we've been trying to look at is what I
 5  pose in some respects.  But trying to maintain this emer
 6  ment that you're constantly trying to counter balance an
 7  r it could be just that I'm trying to keep myself clinic
 8  an acute hospital.  So it's trying to look at those sta
 9  ently in the throes of just trying to sort that one out
10  they are looking at ways of trying to address that.  But
11  a challenge as well you see trying to educate people tha
12  a lot of constraints, we're trying to proactively now ma
```

(Appendix 2 continued)

2.3 Concordances of a lot of/lots of

N	Concordance
1	of education for the staff. A lot of actually the liaison an
2	trons at the QMC campus we do a lot of auditing with them and
3	audit, I'm involved in an awful lot of audits and taking resul
4	s, a lot of complaints. I do a lot of complaints management bo
5	the usual. And there's also a lot of computer work, analysis,
6	we're financially under quite a lot of constraints, we're tryin
7	as well. I also sit on quite a lot of different committees and
8	ogged down by emails I do get a lot of emails like the one I'v
9	e will, there have been quite a lot of issues that have been
10	it takes, it does take quite a lot of managing. So I think t
11	gh bed occupancy and you have a lot of national targets and th
12	ncreased. But where you have a lot of pressures on staff obvi
13	e at the moment because there's lots of extraordinary meetings
14	t's hugely variable, I would do lots of HR type issues, lots a
15	rus, being spread. So we have lots of rigid processes around
16	ots of HR type issues, lots and lots of those kind of things,

2.4 Concordances of issues

N	Concordance
1	on and also the cleanliness issues as well, that's somet
2	et involved in any clinical issues with patients as requ
3	at there's no contamination issues with other patients b
4	e so many infection control issues going on on that, in
5	looking at capital funding issues that that's the one
6	any outstanding maintenance issues or if something is n
7	all the HR, human resource issues within my directorate
8	groups with human resource issues to do with monitoring
9	ooking at infection control issues, looking at environme
10	ts, the service improvement issues, all of those are ba
11	ell. So any staff sickness issues, actually recruiting

Notes

1. CAQDAS proponents are interested in the use of software programs designed to assist data analysis and the methodological and epistemological issues arising from such use (Lewins and Silver, 2007).
2. In corpus linguistics, lemmatization is the process of joining word forms together to calculate the overall frequency of a word. For example, the frequency of the lemma HAVE is made up of joined frequencies of the word forms *having, has, had*.
3. Grammatical words are also called function words (as opposed to lexical/ content words). In our analysis, the grammatical classes of prepositions, pronouns and adverbs were removed from the word lists.
4. As part of our study we also interviewed a number of experts in infection control. The sample included academics, lab-based scientists, and clinical microbiologists.

References

Ackroyd, S. (1996). Traditional and new management in the NHS hospital service and their effects on nursing. In K. Soothill, C. Henry and K. Kendrick (Eds.), *Themes and perspectives in nursing*, pp. 337–55. London: Chapman & Hall.

Adolphs, S., Brown, B., Carter, R., Crawford, C. and Sahota, O. (2004). Applying corpus linguistics in a health care context. *Journal of Applied Linguistics*, *1(1)*, 9–28.

Allan, H. and Smith, P. (2005). The introduction of modern matrons and the relevance of emotional labour to understanding their roles: developing personal authority in clinical leadership. *International Journal of Work Organization and Emotion*, 1(1), 20–34.

Bass, B. and Avolio, B. (1993). Transformational leadership: A response to critiques. In M. Chemers and R. Ayman (Eds.), *Leadership theory and research: Perspectives and directions*, pp. 49–80. New York: Academic Press.

Benoit, W. and Czerwinski, A. (1997). A critical analysis of USAir's image repair discourse. *Business Communication Quarterly*, *60(3)*, 38–57.

Bolton, S. (2003). Multiple roles? Nurses as managers in the NHS. *International Journal of Public Sector Management*, *16(2)*, 122–30.

Bolton, S. (2005). Making up managers. *Work, Employment & Society*, *19(1)*, 5–23.

Brown, B., Crawford, P. and Carter, R. (2006). *Evidence based health communication*. Buckingham: Open University Press.

Clegg, A. (2000). Leadership: Improving the quality of patient care. *Nursing Standard*, *14(30)*, 43–5.

Currie, G., Boyett, I. and Suhomlinova, O. (2005). Transformational leadership in the public sector: A panacea for organisational ills? *Public Administration*, *83(2)*, 265–96.

Dahrendorf, R. (1973). *Homo sociologicus*. London: Routledge & Kegan Paul.

Department of Health, (2000). *The NHS Plan*. London: The Stationery Office.

DHSS. (1966). *Report of the Committee on Senior Nursing Structure (The Salmon Report)*. London: HMSO.

DHSS. (1983). *Enquiry into NHS Management (The Griffiths Report)*. London: HMSO.

Du Gay, P. (1996). Organizing identity: Entrepreneurial governance and public management. In S. Hall and P. du Gay (Eds.), *Questions of cultural identity*, pp. 151–69. London: SAGE.

Enright, M. (2005). MRSA epidemiology & evolution. *Science Lecture*, 21 April. http://www.brlsi.org/proceed05/lecture0405.htm

Goffman, E. (1961). *Encounters*. New York: Bobbs-Merrill.

Grundmann, G., Hori, S., Winter, B., Tami, A. and Austin, D. (2002). Risk factors for the transmission of methicillin-resistant Staphylococcus aureus in an adult intensive care unit: Fitting a model to the data. *Journal of Infectious Diseases*, *185(4)*, 481–8.

Ham, C. (1997). *Health policy in Britain: The politics and organisation of the National Health Service*. London: Macmillan.

Hamilton, C., Adolphs, S. and Nerlich, B. (2007). The meanings of 'risk': A view from corpus linguistics. *Discourse and Society*, *18(2)*, 163–81.

Hewison, A. (2001). The Modern Matron: Reborn or recycled? *Journal of Nursing Management*, *9(4)*, 187–9.

Jeyaratnam, D., Edgeworth, J.D. and French, G. (2006). Enhanced surveillance of methicillin-resistant Staphylococcus aureus bacteraemia in a London teaching hospital. *Journal of Hospital Infection*, *63(4)*, 365–73.

Kouzes, J. and Posner, B. (1997). *The leadership challenge: How to keep getting extraordinary things done in organisations*. San Francisco, CA: Jossey-Bass.

Leech, G. (1991). The state of the art in corpus linguistics. In K. Aijmer and B. Altenberg (Eds.), *English corpus linguistics: Studies in honour of Jan Svartvik*, pp. 8–19. London: Longman.

Lewins, A. and Silver, C. (2007). *Using software in qualitative research: A step-by-step guide*. London: SAGE.

McDonald, J. (2004). My role is a fine balancing act. *Professional Nurse*, *20(1)*, 20.

Mills, C. (1940). Situated actions and vocabularies of motive. *American Sociological Review*, *5(6)*, 904–13.

Millward, L. and Bryan, K. (2005). Clinical leadership in health care: A position statement. *International Journal of Health Care Quality Assurance*, *18(2)*, 13–25.

Moiden, N. (2002). Evolution of leadership in nursing. *Nursing Management*, *9(7)*, 20–5.

Oughtibridge, D. (2003). The modern matron. *Nursing Management*, *10(2)*, 26–8.

Rivett, G. (2007). *National Health Service history*. www.nhshistory.net (accessed 15 September 2007).

Royal College of Nursing Institute (RCN). (2004). *Evaluation of the modern matron role in a sample of NHS trusts. Final report*. London: RCN.

Scott, M. (1999). *WordSmith Tools 3*. Oxford: Oxford University Press.

Seale, C. (2005). New directions for critical Internet health studies: Representing cancer experience on the web. *Sociology of Health and Illness*, *27(4)*, 515–40.

Seale, C. (2006). Gender accommodation in online cancer support groups. *health:*, *10(3)*, 345–60.

Sinclair, J. (1991). *Corpus, concordance, collocation*. Oxford: Oxford University Press.

Skelton, J. and Hobbs, F. (1999). Concordancing: The use of language-based research in medical communication. *The Lancet*, *353(9147)*, 108–11.

Strong, P. and Robinson, J. (1990). *The NHS under new management*. London: Oxford University Press.

Traynor, M. (1999). *Managerialism and nursing: Beyond profession and oppression*. London: Routledge.

Turner, R.H. (1962). Role-taking: Process versus conformity. In A. Rose (Ed.), *Human behavior and social processes*, pp. 20–39. Boston, MA: Houghton-Mifflin.

Woods, L.P. (2000). *The Enigma of Advanced Nursing Practice*. Dunton, Salisbury: Mark Allen Publishing Ltd.

Policy documents

1. Department of Health. (2001). *Implementing the NHS Plan: Modern matrons – strengthening the role of ward sisters and introducing senior sisters* (Health Service Circular 2001/010). London: DH.
2. Department of Health. (2002a). *Getting ahead of the curve: A strategy for combating infectious diseases*. London: DH.

3. Department of Health. (2002b). *Modern matrons in the NHS: A progress report*. London: DH.
4. Department of Health. (2003a). *Modern matrons: Improving the patient experience*. London: DH.
5. Department of Health. (2003b). *Winning ways: Working together to reduce healthcare acquired infection*. London: The Stationery Office.
6. Department of Health. (2004a). *A Matron's Charter: An action plan for cleaner hospitals*. London: DH.
7. Department of Health. (2004b). *Towards cleaner hospitals and lower rates of infection: A summary of action*. London: DH.
8. Department of Health. (2005). *Saving lives: A delivery programme to reduce healthcare associated infection including MRSA*. London: DH.
9. Royal College of Nursing. (2005). *Wipe It Out RCN Campaign on MRSA*. London: RCN.
10. Department of Health. (2006). *The Health Act 2006. Code of Practice for the Prevention and Control of Health Care Associated Infections*. London: DH.

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