Diabetes nurse educators' perceptions of leadership characteristics

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Leadership is a core component of the diabetes educator (DE) role. This study determined the perceptions of leadership of 51 DEs nominated as leaders by their peers. Their views of leadership and details of their leadership activities were collected, along with standard demographic data, using a self-administered questionnaire. Respondents regarded themselves as leaders because they had worked as a DE for a long time, mentored colleagues, worked in a range of practice settings, attended conferences and professional development forums, were well known and had a high profile, were clinically competent, and undertook leadership roles in their workplace. However, these views of leadership were not consistent with the leadership characteristics described in the literature.

There is no formal definition of leadership. The term has several meanings, including "to go before or with [someone] to show the way", "to command or direct" (*Webster's New International Dictionary of the English Language*, 2001) and "the art of persuading people to work towards a common goal" (Goleman, 1996). These definitions suggest that leaders guide and direct, and are easily identifiable (visible).

Earlier philosophical writers suggested that leaders may be effective without being visible: "When the Master governs, the people are hardly aware that he exists" (Lao Tzu, 1999). Lao Tzu goes on to say: "Next best is the leader who is loved. Next, one who is feared. The worst is one who is despised", which suggests that leaders and followers react to, and interact with, each

other in various ways.

Although leadership characteristics are well defined (Reicher et al, 2007; Di Frances et al, 2008), it is difficult to define the exact characteristics that determine whether a leader will be loved, feared or despised, because leadership involves complex relationships that are influenced by the characteristics and personalities of the followers and the leader. Shirey (2006) and Chen et al (2005) suggested that effective leaders have a general interest in people, in supporting patients and colleagues, and in moderating stress and positively influencing coping, well-being, job satisfaction and work effectiveness; this benefits individuals and organisations and improves health outcomes. Reicher et al (2007) suggest that leaders are more effective if their followers regard them as one of the group.

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2. Diabetes education is an important clinical nursing specialty in which diabetes educators work at an advanced, autonomous level to provide education and clinical care for people with diabetes, their families and professional colleagues.

Recently, authentic or positive leadership models that focus on transformational leadership have emerged in business and organisational psychology (Luthans and Avolio, 2003). Transformational leaders play active, directional, and participatory roles to achieve change (George, 2003; Shirey, 2006; Reicher et al, 2007) and engender greater professionalism and improved performance in their followers (Shirey, 2006). They inspire colleagues to develop a shared vision in which the leader, followers and organisation all benefit and inspire each other. Goleman (1996) referred to these attributes as "emotional intelligence". Lao Tzu (1999) similarly observed: "Knowing others is intelligence; knowing yourself is wisdom". Interestingly, like Lao Tzu, some modern leadership experts have suggested that good leaders take care to know themselves. Leadership characteristics include (Goleman, 1996; Shirey, 2006; Di Frances, 2008):

● Having a vision and the ability and capacity to communicate it to others.
● The ability to drive change and take followers with them.
● Reliability.
● Truthfulness.
● Collaborative problem-solving.
● The ability to make difficult decisions.

Leadership in diabetes education

Diabetes education is an important clinical nursing specialty in which diabetes educators (DEs) work at an advanced, autonomous level to provide education and clinical care for people with diabetes, their families and professional colleagues.

Leadership aspects of the role encompass the development of local diabetes policies; acting as role models, mentors and change agents; and providing clinical governance in diabetes nursing, especially in the DE's place of employment. A small minority have national and international leadership roles, and some are academics and researchers. Their leadership attributes and styles are largely unknown. It is possible that DEs adopt active, participatory leadership styles consistent with current diabetes empowerment and collaborative team management strategies.

In Australia, the term "diabetes educator" encompasses members of a range of health professional disciplines, such as nursing (the majority of members), dietetics and podiatry, who have completed a graduate certificate in diabetes education in addition to their primary degree. DEs are also expected to undertake regular professional development activities.

Some preliminary information about DEs' views of leadership emerged in an exploratory study undertaken to determine the types of experiential learning that DEs considered important (Dunning, 2004). As part of the study, respondents were asked to name three DEs who they regarded as leaders, and to give examples of how they demonstrated leadership. Sixty DEs were nominated at least once, range one (median) to 41 (for one DE) nominations. Subsequently, a cross-sectional survey involving the 60 nominated leaders was undertaken to ascertain their perceptions of leadership. The results of the survey are reported below.

Aims of the study

The aims of the study were to determine:
● Whether the 60 DEs nominated as leaders by their peers considered themselves to be leaders.
● The DEs' perceptions of the characteristics and attributes that made their peers nominate them as leaders.
● Whether the DEs' perceptions were consistent with the literature.

Methods

Sampling population
The sampling population comprised the 60 DEs who were nominated as leaders by their peers in a previous study. The original sample included all DEs listed on the Australian Diabetes Educators Association (ADEA) Victorian Branch membership

database in 2007 (n = 225). These DEs and the 60 DEs they nominated as leaders worked in a range of metropolitan and rural practice settings, including tertiary hospitals, general practice and private practice.

Data collection

Data were collected in a one-shot cross-sectional survey in July 2007, using a self-completed anonymous questionnaire. The questionnaire was developed specifically for the study, and tested for validity by a panel of six diabetes experts.

The questionnaire collected standard demographic data such as work location, health professional discipline, age, gender and years worked as a DE. There were questions concerning creating and driving change, improving performance, and the ability to manage change.

Other questions sought information about the DEs' perceptions of leadership, whether they considered themselves to be leaders in diabetes education and management, and whether they were surprised to be nominated as leaders by their DE colleagues. They were also asked to describe key leadership characteristics and attributes, and to outline their participation in leadership activities, such as committee work, publications, presentations, policy development and research.

The questionnaire was mailed to each DE, together with a covering letter and a stamped self-addressed envelope to encourage return of the questionnaire. Non-respondents were not followed up.

Ethical approval

Ethical approval to conduct the study was obtained from the human research ethics committees of the hospital and university where the two researchers are employed. Potential conflict of interest was declared and the collegial relationship of one of the researchers to respondents was acknowledged. Return of the questionnaires was taken as consent to participate.

Data analysis

Data were analysed using descriptive statistics, including frequencies and percentages. Content analysis of open-ended questions was undertaken using the framework method (Ritchie and Spencer, 1994). This is a five-step process that involves becoming familiar with the data, identifying a thematic framework, indexing and charting key themes, mapping and interpreting the findings. The research team, and one independent academic who was familiar with Ritchie and Spencer's method, undertook content analysis independently, and then discussed their findings to reach a consensus.

Results

Fifty-one DEs responded, giving a response rate of 85%. Most respondents provided extensive answers to the questions.

Demographic data

All respondents were female. The largest age group was 49–59 years (46.2%). Respondents worked in a range of metropolitan public (54.3%), community and rural general practice (33.7%) and private health settings (12%). Most were nurses (one was a dietitian), and 10 managed the diabetes education services of major metropolitan public hospitals.

All respondents had ≥10 years' experience in diabetes education, and ≥5 years in other areas of nursing. All had graduate Certificates in Diabetes Education, but only three had other postgraduate qualifications: one had a PhD and two had Master's degrees.

The response rate and demographic data were similar to those of other studies carried out in the ADEA population (Dunning, 2004).

Perceptions of leadership

All 51 respondents considered themselves to be experienced, or very experienced, clinicians and most felt they were DE leaders, particularly in their places of

Table 1. Reasons given by the diabetes educators (DEs) as to why their peers had nominated them as leaders (n = 51)	
Reason	**No. of responses***
Time spent in the job as a DE	50
Worked in a range of practice settings	48
Give advice or are contacted for advice by colleagues	40
Well known or have a high profile	33
Leadership role in employing organisation	30
Seen as a leader	27
Develop resources and teaching tools	20
Visibly keep up to date, for example being seen at professional development forums	20
Have a postgraduate qualification(s)	6

*The number of responses total more than 51 because some respondents gave more than one reason

employment. Only three were surprised that their peers regarded them as leaders. The reasons DEs thought their peers regarded them as leaders are shown in *Table 1*. The two most common reasons were time spent working as a DE (50 responses), and having worked in a range of practice settings (48 responses).

Characteristics of leaders

Five main characteristics of DE leaders were identified, and are listed in *Table 2*.

Time in the role

Having spent a long time working in diabetes education and becoming experienced emerged as the central component of DE leadership, and was the major reason that respondents felt their peers regarded them as leaders. For example:

"I would say that I have been around for a long time so I have experience as a DE. Because I have been around for a long time, people see me as a leader and come to me for advice."

Respondents felt that time in the role enhanced their clinical competence and

knowledge, which in turn contributed to their leadership status. In addition, time in the role increased their authority and profile within diabetes specialty practice, which led to invitations to undertake leadership activities such as committee work, especially in the ADEA and each DE's place of employment. In particular, respondents gained a range of clinical, administrative and leadership experiences with increasing time in the role, which they felt gave them the confidence to undertake leadership. Clinical experience was seen as essential to DE leadership, and respondents felt that being in the DE role for a long time indicated clinical competence.

Mentoring

Mentoring was closely linked to time in the role. DEs who acted as mentors felt that they helped their colleagues develop clinical skills and competence through direct guidance, being a role model, and supervising newly qualified DEs as part of the ADEA mentoring and credentialling process (ADEA, 2008).

Respondents felt that they were approached to act as mentors because of their high profiles ("visibility"), clinical skills and being in the role a long time, which meant they were well known. Twenty-two respondents felt that being asked to be a mentor indicated that they were opinion leaders. Others felt that they had been asked to act as a mentor because they were non-judgemental.

Having a high profile

All respondents indicated that "recognised" DE leaders, including themselves, had a high profile and were well known. In addition, 33 felt that working in a range of different places increased their chances of becoming "well known in the field" and gave them a high profile. One said:

"Working in different places – people get to know you. You build a profile."

Some respondents actively and deliberately

engaged in professional activities to build a profile, and linked "being well known" to their scope of practice and collegiate relationships:

"I think it has to do with the profile I have, and I take the opportunity through the ADEA and supportive colleagues to extend my scope of practice and experience and therefore develop my profile."

Six other respondents felt that "sharing company with the movers and groovers" contributed to their leadership profile, and helped them become well-known. These respondents realised that they were "bathing in reflected glory" but saw such associations as important learning opportunities that could advance their careers. They deliberately selected well-known DEs as mentors and associated with them at conferences and socially to increase their own personal and professional profile. One respondent felt that working closely with an endocrinologist facilitated her clinical learning, which in turn contributed to her leadership status at an organisational level.

Clinical competence

Forty-one respondents indicated that clinical competence was a vital attribute of clinical (as distinct from academic and organisational) leaders. They felt that postgraduate qualifications and ADEA credentialled status were forms of "visible knowledge" that denoted clinical competence.

However, 26 respondents felt that having a high profile does not necessarily indicate clinical competence, and suggested that there is a difference between perceived and actual knowledge and competence. They felt that some DEs might assume that their colleagues were experienced, competent clinicians because they had been in the job for a long time and had a high profile (were visible), rather than actually knowing they were competent. One DE who does not

have a postgraduate qualification or ADEA credentialled status said:

"My perception is that some local educators perceive my knowledge base as not up to standard just because I don't have the diploma or ADEA credentialling. They do not actually know whether I am competent or not."

The unconscious leader (quiet achievers)

Although not a major theme, seven respondents viewed themselves as "quiet achievers" and three were surprised that their peers regarded them as leaders. Even though they were "unconscious leaders" (Lao Tzu, 1999), these DEs were visibly leaders to their peers. For example:

"I am non-political. I consider myself to be a quiet achiever so I thought nobody knew what I did. I was kind of invisible, you might say, from a leadership point of view. Because I work in isolation I was not aware that others were aware of my practice. I did not think I had a very high profile."

One of the seven quiet achievers takes on leadership roles in the ADEA "because nobody else will", rather than because she

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Table 2. Reported indicators of leadership (1 = most commonly reported; 5 = least commonly reported).

1. Time in the role, which encompassed clinical skills, being highly visible and being well known.

2. Mentoring and supervising student diabetes educators (DEs) undertaking a postgraduate Certificate of Diabetes Education and those preparing for credentialing.

3. Having a high profile, which was linked to time in the role and being an opinion leader and working in a range of general nursing and DE practice areas and geographical locations.

4. Clinical competence.

5. Working in niche areas such as wound management, insulin pump therapy and care of older people.

is committed to leadership or professional development. Thus, she does not consciously set out to develop a high profile or take on leadership roles.

The seven quiet achievers viewed being nominated as a leader as a form of peer review. They were very pleased to be nominated and felt that being regarded as a leader by their peers represented a positive affirmation of their contribution to diabetes education and management. Three of the seven felt humbled and flattered by their peers' recognition.

Thirty DEs had leadership roles within their employing organisations. However, none of the 51 respondents were current members of an ADEA committee, and only three had previously held leadership positions in the ADEA. Thus, these respondents felt that they were local leaders but not necessarily visible outside their workplace, or to their ADEA colleagues.

Three respondents felt that diabetes in a family member, or having diabetes themselves, conferred a particular type of experience that enabled them to take on leadership roles, especially as consumer advocates.

Working in niche areas

Four DEs felt they were able to develop leadership skills because they worked in niche diabetes areas, such as care of older people, wound care and insulin pump therapy. These respondents felt they had a high profile because there was little competition in these niche areas. As a result, they were highly visible.

Other aspects of being well-known that respondents felt denoted leadership were regular attendance at diabetes conferences and workshops (30 responses), presenting at diabetes conferences (12 responses), and undertaking postgraduate degrees (8 responses). Interestingly, respondents confined their comments to the diabetes field. No respondent reported undertaking academic leadership activities, such as writing professional publications or

committee or research work.

Discussion

The study provided interesting information on DEs' perceptions of leadership characteristics not previously explored. However, these do not reflect the current literature on leadership: for example, time spent in the DE role, being well known, mentoring, and clinical competence might mean that people are visible and well known, but does not necessarily mean they are effective leaders.

Mentoring is a leadership role, but respondents did not indicate how they demonstrated leadership qualities when mentoring colleagues. Likewise, the reasons they were approached to be mentors are not clear, and may have had more to do with convenience rather than leadership skills (Lewis, 2000).

Importantly, older, experienced, physicians who have spent considerable time in their roles are less receptive to new ideas, and are likely to deviate from practice standards (Choudhry and Fletcher, 2005). Choudhry and Fletcher's findings might apply to other health professional groups who work closely with physicians, including DEs, and is an area worthy of further study. Their findings also raise questions about the desirability of assuming that a person is a competent leader or clinician because they have worked in a role for a long time.

Newly qualified DEs often need assistance to determine their learning needs, in contrast to more experienced practitioners who are better equipped to recognise and seek learning opportunities (Barrington, 1997). Diabetes is a rapidly changing field, with information available from many sources. Keeping up with information is difficult, and may be a key factor in the development of nursing specialties such as diabetes education, which in turn enable mentors and leaders to emerge. However, if mentors' knowledge is outdated they may not promote best practice, which is a key leadership attribute.

ADEA credentialling also emerged as an important indicator of leadership. However, the ADEA credentialling process is a record of continuing professional development activities; it may not indicate clinical competence and does not include leadership characteristics. Mentoring is a key aspect of the credentialling programme (ADEA, 2008). More DEs are applying for credentialled status as the benefits of credentialling, such as governmental reimbursement for diabetes education services, become more widely available. Credentialled DEs are therefore likely to be asked to mentor their colleagues as they undertake the credentialling process.

Mentoring is an effective way to help people develop professionally (Lewis, 2000) and an important workforce and succession planning strategy. Lewis (2000) regarded mentoring managers as a new style of leader who is concerned with continuing professional development, multiskilling and technological competence. Mentoring styles were not explicitly explored in the current study, but are likely to be influenced by factors such as the personalities involved, and the environment in which mentoring occurs.

Although the findings from the current study demonstrate that most DEs who are regarded as leaders had a high profile, some respondents were surprised that their peers viewed them as leaders, because they felt they were not highly visible. This suggests that the notion of a leader as someone who stands out and has power over followers may not be relevant in the current healthcare climate (Lumby, 2005). It also demonstrates that individuals can inspire others without necessarily holding formal leadership positions.

Other respondents deliberately sought the company of the "movers and groovers". It is not clear whether the "movers and groovers" realised that they were acting as role models and unknowing mentors. If not, they could be regarded as "unconscious" or invisible leaders.

Box 1. Recommendations for practice

- Diabetes educator (DE) leaders need to be identified, acknowledged and supported.
- DE professional organisations could implement formal leadership development programmes or collaborate with existing programme providers to support existing DE leaders and succession plan for the future.
- A structured approach to preparing DEs for leadership roles and building DE leadership capacity needs to be considered and could be incorporated into diabetes postgraduate degree courses.
- The leadership qualities of, and respect accorded to, informal DE mentors needs to be considered when an Australian Diabetes Educators Association credentialling and mentoring process is evaluated.

The findings suggest that naturally evolving relationships with colleagues, including medical colleagues, enabled some DEs to take on leadership roles. Certainly, through such relationships, a few DEs have been able to have a voice in developing national and international diabetes strategic policies and influencing clinical practice.

The findings show that DEs value clinical leadership, which is consistent with Bryant's (2004) view that "patients are central to excellence in nursing leadership". Universities are currently focusing on developing academic and management leaders, especially researchers. Equal time and effort needs to be directed towards preparing, supporting and valuing clinical leaders.

Most DEs appeared to have a clear concept of their self-worth and regarded themselves as valuable, experienced clinicians who were able to lead and support their peers. They also appeared to regard themselves as participatory leaders, which is in keeping with, and could be influenced by, current diabetes education empowerment management. Likewise, it suggests that most DE leaders have moved away from "control and command" leadership styles towards collaborative empowering styles (McLean, 2004). *Box 1* shows the recommendations for practice.

Page points

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3. Most DEs appeared to have a clear concept of their self-worth and regarded themselves as valuable, experienced clinicians who were able to lead and support their peers.

Limitations of the study

The sample was purposely chosen and may not reflect the views of all DEs. Likewise, there may be other effective, less well-known DE leaders who were not nominated as leaders by their colleagues in the original survey and were therefore not included. The findings are the perceptions of the respondents and may not totally reflect actual leadership practice and skills. The questionnaire had face and content validity and performed well for the purposes of the study, but was not formally validated.

Conclusions

The DEs in this study considered themselves to be leaders and most were not surprised that their peers regarded them as leaders. The main reasons they gave for being regarded as leaders were time spent working in diabetes education, being well known, and mentoring colleagues; however, these reasons are not consistent with the leadership characteristics described in the literature.

Clinical competency was considered an important DE leadership attribute and was associated with the ADEA credentialling process, which is a continuing professional development and peer-review process, rather than a means of assessing competence or leadership capabilities.

While this study investigated the perceptions of DEs in Australia, it would be interesting to investigate the views of DEs in the UK, and compare the perceptions of leadership characteristics between them. ∎

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