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Human-centred leadership in health care: A contemporary nursing leadership theory generated via constructivist grounded theory

Lucy Leclerc PhD, RN, NPD-BC, Assistant Professor, Principal[1,2] | **Kay Kennedy DNP, RN, NEA-BC, CPHQ, Clinical Instructor**[2,3] | **Susan Campis MSN, RN, NE-BC, Principal**[2]

[1]WellStar School of Nursing, Kennesaw State University, Kennesaw, GA, USA

[2]uLeadership, LLC, Stone Mountain, GA, USA

[3]Nell Hodgson Woodruff School of Nursing, Emory University, Atlanta, GA, USA

Correspondence
Lucy Leclerc, WellStar School of Nursing, Kennesaw State University, 520 Parliament Garden Way, Prillaman Hall, Rm #3027, Kennesaw, GA 30144, USA.
Email: lucyleclerc300@gmail.com

Abstract

Aim: To generate a unique and contemporary leadership theory reflecting the essence of nursing within a complex health care environment.

Background: As health care faces unprecedented change and increasing complexity, a nursing leadership theory embedded within complexity science is vital for teams to be innovative, nimble and focused on human-centred care.

Methods: Constructivist grounded theory framed exploration of human issues embedded in nursing leadership. The constructivist approach sought thematic and theoretical sensitivity through the rich co-creative experience of participants, researchers, literature and data. Focus groups were convened over 18 months with 39 nurse leaders from bedside to boardroom.

Results: Constant comparative methods resulted in 15 attributes. Advanced coding positioned the 15 attributes into constructs: Awakener, Connector and Upholder. Definitions emerged through the constructivist process organically connecting attributes and constructs to the potential outcomes identified in the theory as cultures of excellence, trust and caring.

Conclusions: The final constructivist process revealed a nursing-specific theory: human-centred leadership in health care uniquely suited to assist leaders in addressing structure, process and outcomes.

Implications for nursing management: Efforts by nurse leaders to test the theory with metrics related to nursing excellence will result in validation of the theory and validation of the proposed sustained culture change.

KEYWORDS

constructivist grounded theory, cultural change, human-centred leadership, nursing leadership

1 | BACKGROUND

Theories make phenomena and their relationships visible in a way one could only sense beforehand through experience and shared stories. Theories are made up of words and constructs to describe concepts with no physical referents. Nursing has generally borrowed theories from the business world to explain leadership styles. Nurse leaders tend to describe themselves as "transformational" or "servant". Why has nursing not yet explored the invisible yet "known" unique way of leading in health care that leaders and their followers

have sensed for decades? Human-centred leadership in health care is a contemporary theory, some might call it a movement, that's time has come. The development of this unique leadership theory reflects the essence of nursing within a complex health care environment by providing a framework for health care's largest workforce of over 3 million nurses to lead through chaotic times and into the future (Smiley et al., 2018).

The phenomenon of nursing leadership as a social process rooted in human interactions within complex micro- and macrosystems has not been well documented or researched in the literature. While much research and writing have been done on other forms of leadership such as traditional, servant and transformational leadership, there remains a gap in the literature to document the approach experienced by many nurses and nurse leaders. Nursing leadership research remains deficient in developing a unique theory or philosophy clearly defining and explaining the repeated anecdotal experiences of nurse leaders who skilfully merge an eye for metrics while recognizing the humanity in the cared for and those doing the caring (Porter-O'Grady & Malloch, 2018; Weberg & Fuller, 2019). Thus, the purpose of this constructivist grounded theory research was to explore and explain how nurses and nurse leaders respond to and navigate the landscape of caring for complex humans within an industry confronted with high-stakes pressure to be efficient, lean and profitable. The research questions guiding this work include the following: What are the attributes of nurse leaders who are effective in balancing the human-centred needs of their teams and patients while achieving positive patient outcomes, meeting operational metrics and creating sustained culture change?

Although review of the literature in grounded theory has been historically debated as potentially tainting the researchers' ability to observe as a blank slate, constructivist grounded theory believes a thoughtful, reflective and critical appraisal of existing research and literature provides an informed grounded theory (Charmaz, 2014; Thornberg, 2012). Thus, a literature review is included as one of the multiple perspectives in informing the theory of human-centred leadership. The extensive literature review utilized various databases including CINAHL Complete, ProQuest Nursing, Access Medicine, Cochrane Library and PubMed. For a complete historical perspective, the literature search included peer-reviewed articles published between 2000 and 2020 using search words: nursing leadership, nursing leadership conceptual models, nursing leadership conceptual frameworks, nursing leadership theory, health care leadership, health care leadership models and cultural change. The results revealed distinct themes regarding the most commonly employed models within nursing and health care leadership, which are notably borrowed from other disciplines: traditional, servant and transformational. An exhaustive literature search revealed one proposed nursing-specific leadership theory based on a nursing practice theory: dynamic leader–follower relationship model (Laurent, 2000); and one nursing leadership conceptual model: person-centred leadership (Cardiff, McCormack, & McCance, 2018). The literature review provided within this manuscript targets the most commonly used leadership models within health care and nursing as a means of identifying the gap in nursing-specific models and theories for leaders within complex health care systems. It is from this unique starting point of historical evidence to indicate nursing's use of borrowed theories that the authors were able to inductively study the more specific experience of nurse leaders through constructivist grounded theory (Charmaz, 2014).

Traditional leadership also commonly referred to as "linear", "bureaucratic" or "transactional" is typically understood to be top-down. The leader is at the top of the structure, and the followers or workers are employed to accomplish the goals set forth by the leader. Porter-O'Grady and Malloch (2018) describe traditional leadership thinking as: vertically oriented, hierarchical, mechanistic, reductionistic, compartmental and controlling. Traditional leadership is generally authoritative and transactional with minimal or no input from the workers at the point of service, which may squelch innovation and ownership in the work environment (Weiss, Tappen, & Grimley, 2019). A traditional leader expects unit- and organisational-level outcomes to result from the leader's authority or influence over the workers at the point of service as a means to control the environment and favour achievement of the expected outcomes. Traditional leadership styles tend to focus on efficiency, quantity and little freedom for team members to share innovation and ideas. The results of this approach are often mixed with high output and achievement of goals; however, the team members often experience less trust and low morale (Crowell, 2016; Weiss et al., 2019).

The transformational leadership model was established in 1978 by James McGregor Burns, a political scientist and noted scholar in leadership studies (Marquis & Huston, 2017). Extending the work of Burns (1978), Bass (1985) introduced transformational leadership theory and used the word "transformational" in place of "transforming". Bass conducted a psychometric study by developing and validating a multifactor leadership questionnaire with four components of transformational leadership: (a) idealized influence; (b) inspirational motivation; (c) intellectual stimulation; and (d) individualized consideration (Bass, 1985). Transformational leadership has been effectively used in diverse business sectors including the military, education, organised religion and human services. The hallmark of a transformational leader is someone adept at casting a shared vision that allows followers to invest and engage in actions creating momentum towards the common vision (Lin, Scott, & Matta, 2019; Weiss et al., 2019). Professional nursing has embraced the use of transformational leadership, and it is one of the five key components of the American Nurses Credentialing Center (ANCC) Magnet Recognition Program for establishing Magnet status in nursing care (ANCC, 2015). The effective transformational leader focuses less on managing change and more on the strategy around aligning followers with organisational goals and metrics (ANCC, 2015; Lanaj, Johnson, & Lee, 2016; Weiss et al., 2019). While much research has examined the effects of transformational leadership on those being led and the organisation, Lin et al. (2019) explored the effects of transformational leader behaviours on leaders themselves. Through two experience sampling studies, Lin, Scott, and Matta discovered the "dark side"

of transformational leadership, which indicates the one-way street of influence and energy to cast and deliver on a vision results in an increase in leader emotional exhaustion, burnout and leader turnover intentions.

Servant leadership is one of the more commonly borrowed theories or philosophies of leadership embraced within health care and nursing (Hall, 2015; O'Brien, 2011). Servant leadership is defined as an understanding and practice of leadership that places the good of those led over the self-interest of the leader. Servant leaders place the needs of others before their own and embrace a fundamental motivation to serve (Greenleaf, 1977; O'Brien, 2011). Servant leadership characteristics are rooted in altruistic motivation with primary characteristics including listening, empathy, awareness, persuasion, foresight, stewardship and commitment to the growth of people (Greenleaf, 1977). Parris and Peachey (2013) performed a systematic literature review of servant leadership in organisational contexts across 39 research studies and found no consensus on the definition of servant leadership and found researchers used multiple measures to investigate servant leadership. Positive findings indicated servant leadership is considered a viable leadership theory that assists organisations in improving the well-being of the followers. The potential challenges of systemic use of servant leadership in health care lie in a lack of evidence-based and standardized definitions, and connections to metrics such as quality, safety and patient satisfaction. Servant leadership remains untested in a systematically empirical way with a plethora of narratives and anecdotal literature that have not researched the basic constructs and relationship to outcomes (Parris & Peachey, 2013).

Nursing-specific theories for practice are prevalent; however, nursing leadership theories are a rare find. Laurent (2000) conceptualized differences between management and leadership theory and proposed a leadership theory utilizing Ida J. Orlando's model for nursing. Laurent's model of dynamic leader–follower builds on Orlando's (1961) model for practice with proposed implications on how to transform managers into leaders. Laurent posits similar concepts tested within Orlando's nurse–patient relationship would align with the leader–follower relationship model; however, there are no studies or research publications testing Laurent's proposed model. Cardiff et al. (2018) proposed a conceptual framework specific to nursing developed through participatory action research: person-centred leadership. Cardiff and colleagues created a graphic and narrative representation of clinical nursing leadership as person-centred and relational. The strengths of person-centred leadership framework lie in the alignment with other commonly used leadership styles such as servant leadership; however, person-centred leadership was developed with an "others-oriented" focus that fails to recognize the leader's need to start with self. The deficits in exploring self-care and self-awareness of the leader revealed a gap for this research team's aim to explore how self- and others-oriented paradigms are integral to successful leadership in nursing. Also, Cardiff et al.'s study was limited to one nursing unit within a hospital, thus creating a limited range of perspectives across settings and specialties.

2 | METHODS

2.1 | Constructivist grounded theory

Constructivist grounded theory is a research paradigm that evolved from the epistemological underpinnings of Glaser and Strauss (1967) who revolutionized the methodology of grounded theory (Charmaz, 2008, 2014). Grounded theory is a methodology that pursues construction of theories to explain human issues embedded in society. These are issues not formally named or identified; rather, they are human complexities sensed and brought to life through generation of theories to explain relationships between non-physical referents (Charmaz, 2014). Constructivist grounded theory epistemologically emphasizes the interrelationship between the researcher and participants to construct shared meaning. Researchers' humanity is recognized as part of the research effort by placing the researchers squarely within the methodology to impart acknowledgement of their experience, expertise and values as vital contributors to the process and outcomes. This is the revolutionary aspect of constructivist versus traditional grounded theory as traditional approaches advise researchers to be a tabula rasa, a blank slate, to attain theoretical sensitivity (Glaser, 1978). In contrast, the constructivist approach asserts theoretical sensitivity is attained through the rich co-creative experience of participants, researchers, the literature and the data.

2.2 | Initial thematic saturation

IRB approval was obtained through the researchers' affiliated university. Researchers documented narrative field notes over a period of nine months in which their own experiences revealed potential trends and themes in unique nursing leadership experiences from the bedside to the board room. The three researchers each have over 30 years of experience as registered nurses with diverse backgrounds in executive leadership from charge nurse to executive director to chief nursing officer. The researchers coded their narratives, and an initial thematic saturation of theoretical propositions was achieved. Because saturation at a rigorous level means more than a one-time checkpoint and is something not proclaimed, rather it is achieved, the researchers' next step was to seek theoretical sampling with a broader audience of nurses from the bedside to the board room (Charmaz, 2014).

2.3 | Theoretical saturation

The population of interest was nurses from the bedside to the boardroom who had experienced nursing leadership either as the leader or as the person being led. A heterogeneous purposive sampling plan was employed to gain a sample representative of nurse leaders at all levels: bedside, middle management and executive leadership. The sample was garnered through researchers'

professional networks and was comprised of a diverse range of participants to represent the common attribute of nursing leadership. Basic demographics were collected. The sample included 39 nurse leaders in acute care organisations representing specialties including medical/surgical, obstetrics, perioperative, oncology, orthopaedics, paediatrics, neonatology, nephrology, critical care and administration. The roles included the following: 15 front-line/charge nurses; 10 front-line clinical nurse specialists; 10 unit-level nurse managers; 2 executive directors; and 2 chief nursing officers. The age of participants ranged from 24 to 62 years with mean of 42. Years of experience ranged from 3 to 35 with mean of 20. Face-to-face focus groups were held at neutral settings not associated with a particular organisation or hospital. Focus groups lasting 60–90 min that were comprised of participants ranging in number from five to 12 with a mix of front-line and executive nurses were facilitated by the three researchers over a period of six months until theoretical saturation was achieved. The researchers performed iterative co-constructivist coding following each focus group, which led to the achievement of theoretical saturation. Informed consent indicating data and findings would be de-identified was obtained from each participant prior to beginning each focus group. A copy of the signed informed consent was retained, and a copy was provided to the participants.

The focus group interviews were facilitated with foundational questions to guide inquiry regarding social processes and social psychological processes surrounding lived experiences in nursing: being led or being the leader. Standard questions were employed to start the conversation. The researchers planned for intermediate questions to supplement the dialogue; however, the two initial questions sparked robust dialogue (see Table 1). All researchers were present for all focus groups. For consistency, one researcher led the facilitation, while the remaining researchers observed and took extensive field notes. Each participant was ensured equal participation and voice by use of adhesive paper squares, which assisted the facilitators in categorizing the participants' ideas and words. The facilitator then member-checked the data and categories in real time with the participants to clarify words, in vivo expressions and phrases. The focus groups were not recorded because of the nature of the groups' dynamic relationships and power gradients. The primary intention was to provide a safe space for sharing potentially traumatic and inspiring experiences within a group setting. The group setting also provided an environment of shared experience in which ideas organically expanded into rich stories and narratives.

2.4 | Data analysis

Field notes were analysed using constant comparative methods and coded for thematic and saturated theoretical concepts. Coding is the process of assigning interpretive labels to ideas, constructs or concepts that arise from the data (Carmichael & Cunningham, 2017; Saldaña, 2016). Initial line-by-line open coding of detailed field notes or the "what?" phase was employed with identification of initial codes to separate data into categories, that is social processes or social psychological processes (Charmaz, 2014). Attention was also placed on in vivo coding aimed to preserve the precise words or terms "known" to a specific group such as health care workers and nurses. In vivo codes are innovative terms or statements that crystallize the participants' thoughts, concerns or ideas surrounding their experience (Charmaz, 2014). Intermediate focused coding, also known as concept coding or the "so what?" phase, directed the analysis to identify themes illustrating central concepts and *meaning* of the nurses' experiences as leaders and as being led in a complex environment. The final step was advanced coding to address the "now what?" part of the research process in which the researchers considered the *implications* of the meaning in regard to a macro level or organisational and societal perspectives. This final stage facilitated co-constructivist emergence of a conceptual model of human-centred leadership in health care with logical and connected attributes, concepts and constructs (Birks & Mills, 2015; Charmaz, 2014; Singh & Estefan, 2018) (see Figure 1). Member-checking was then performed by providing the participants with an opportunity to review the major categories, concept definitions and model to ensure congruence with each participants' experience (Charmaz, 2014). Member-checking was achieved by sharing documents via email as agreed upon in the original informed consent and focus group. The researchers also offered one-on-one meetings or phone calls with the participants. There was unanimous approval and confirmation of the participants' experience as accurately translated into the conceptual model of human-centred leadership.

3 | RESULTS

The iterative co-constructivist analysis provided organic and thoughtful evolution of concepts emerging from the multiple levels of coding and stages of thematic and theoretical saturation. In response to the foundational interview questions: (a) How would you describe a leader you would follow to the end of the earth? and (b) How would you describe the nurse leader who, perhaps, has caused you to leave a position or move to another unit?, *initial coding* allowed respondents' in vivo codes and responses to be mapped within a matrix that included categories (see Table 1). *Intermediate coding* resulted in 15 thematic attributes that were then recorded within Table 1 to capture the essence of the participants' comments in relation to categories and concepts. Using *advanced coding*, the 15 attributes were then mapped into three constructs identified within the theory: Awakener, Connector and Upholder (see Table 2). Table 2 indicates the categorization of the attributes within the constructs and includes definitions of each attribute and each construct. The final stage in the constructivist process organically connected the attributes and constructs to the potential implications indicated by outcomes identified in the theory as cultures of excellence, trust and caring (Wong, Cummings, & Ducharme, 2013). The researchers used the nursing industry's

TABLE 1 *Initial Coding* (Category/Concept with Dimensions); *Intermediate Coding* (Identification of attributes); *Advanced Coding* (Placing attributes within constructs, developing definitions)

Awakener: Cultivating our People → Culture of Excellence		
Category/Concept	**Dimension**	**Attribute**
Supports growth and development	a. "need leaders who want you to grow" b. Extends ownership of growth along with support c. Promotes growth and building the team	Advocate Motivator Mentor
Mentor/Coach	a. Knowledgeable about leadership roles b. Can mentor new leaders effectively c. Can help others understand the leadership role d. "flexible but needs to know where the line needs to be drawn", "flexible versus not knowing when to be flexible"	Coach Mentor
Visionary	a. A good leader needs to have a vision in order to know where the team is going. They need to have an understanding of how to get there and then good communication skills to get the team on board b. Sees opportunity in everything	Architect Motivator
Leads by example	a. multiple mentions of leading by example in regard to work/life balance, relationships, skills as a leader, skills as a nurse, honesty, transparency, trust, communication, development, self-care b. Nurses nurse c. "walk the walk" d. "I do what you do" e. Resource to the team f. *Knowledgeable/competent	Coach Mentor Advocate
Team Player	a. Willingness to be "out there"—side by side with staff b. No separation between co-worker and boss c. Has a transformational style of leadership and understands that good leadership involves a "give and take" mentality. d. Collaborator—"I'm a nurse with more paperwork" e. Symbiotic	Advocate
Knowledgeable/ Competent	a. Need to be able to do what they ask nurses to do b. Act as a resource—"if you don't know the answer, you know where to go to find the answer" c. "When leader speaks on behalf of the staff, they need to have the knowledge base and competency level to speak intelligently…knowing what the nurses do"	Coach and mentor Advocate
Connector: Building our Community -> Culture of Trust		
Category/Concept	**Dimension: participant comments and in vivo codes**	**Attribute**
Communication	a. "Forthright" b. "two-way conversation" c. "transparent, not political" d. Good at conflict resolution e. Safe environment f. "don't be a 'yes' man…let me in on the 'why' if it can't be supported" g. Will disagree with you	Authentic Communicator
Empowering	a. Autonomy: allows it, supports it, expects it b. Confidence in team, that is "appreciates that work will get done". c. Supported: helps identify and resolve barriers d. "Identify the goal, then support me…offers some autonomy… shows interest in my work and abilities" e. "opinion seeker" seeks my opinion f. "seeks opinions and actually listens" g. Offers choices and honours and supports them h. 'respects analytical nature of team members'	Engineer Supporter Collaborator

Connector: Building our Community -> Culture of Trust		
Category/Concept	**Dimension: participant comments and in vivo codes**	**Attribute**
Trustworthy	a. Integrity, honesty (mentioned multiple times) b. Leader's trust is earned c. Respect is earned d. Does not gossip, is not 'catty' e. Offers 'safe space' and encourages a culture of honesty with staff f. Kind to everyone and understands that staff are human being and are fighting life's battles g. Gives credit where credit is due	Authentic Communicator Supporter
Innovative	a. Ability to get staff 'buy in' b. Ability to see the big picture c. Be a part of the process, d. Understand and embrace change versus 'we have always done it this way' e. Attitude that 'we may lose the battle, but we will win the war' f. 'appreciates people who think differently'	Edgewalker
Upholder: Recognizing Humanity in Others → Culture of Caring		
Category/Concept	**Dimension: participant comments and in vivo codes**	**Attribute**
Recognizes Humanity Humility	a. "treats me like a person" b. Authentic (multiple) c. "School doesn't 'prepare' you for leadership, are leaders born?" d. Can build relationships e. Respectful as a person and position f. "recognizes me as a unique individual" g. Compassionate h. "has compassion for human aspect, i.e.., life health" i. Respects the leadership role j. Has ability to seek assistance when needed k. The leader reflects the team, who they are, not a reflection of the leader l. selfless	Others oriented Emotionally aware
Self-care	a. Work/life balance b. Supports team members' work/life balance c. Provides role model for this d. "work is only one part of life" e. "having a leader who recognizes our team is better off if team members are 'health' with home and balance of work/life". f. "we're a caring profession…we need to learn to care for ourselves"	Personal well-being
Fair	a. Does not play favourites b. Supports just culture c. Provides a safe environment d. Gives a "fair chance" to everyone. Example: If there is a patient complaint, a good leader will not only talk to the patient but will follow up with the nurse to hear her story. Not quick to "judge" e. Understands both sides f. Advocates for the nurse g. Respectful of everyone: example: My manager is over 2 different units, but she has the same expectations for each unit, she has no favourites and is consistent in her communication h. "You work hard for me; I'll work hard for you" i. Fair with feedback, both good and bad j. A fair leader is like a balance beam k. Takes ownership of managers' responsibilities l. "not necessarily popular"	Socially and organisationally aware

Upholder: Recognizing Humanity in Others → Culture of Caring		
Category/Concept	**Dimension: participant comments and in vivo codes**	**Attribute**
Motherly	a. "mama bear" b. Supportive c. Empathetic d. Defends staff e. Staff advocate	Others oriented
Kind	a. Understanding b. Relates to staff experiences c. Always remembers "where she/he came from" d. Empathetic e. Present f. Has ownership of the team g. Listens	Mindful
Resilient	a. Ability to bounce back b. When responsibilities change, the leader does not complain or get frustrated. They adjust and continue to cheer on the team c. Example: A unit with many new nurses experience a Code Blue. This was the first code situation for many of these new nurses. The leader had the ability to support the nurse and continue with the code even though it was a stressful event. d. Offers support both physical and emotional e. Emotional intelligence	Socially and organisationally aware Mindful

highest standard of excellence, ANCC (2015) Magnet standards, as a compass to map the connection between human-centred leadership constructs and cultures (see Table 3). The culmination of this multiple years' research journey resulted in the final logical connection between historical perspectives, the literature, the participants' voices, the data and the researchers' placement within the process, which is the model reflecting the theory: human-centred leadership in health care (see Figure 1).

3.1 | The Awakener

Consistent themes emerged around what it means to be led by and to be the leader who cultivates the humans entrusted to their care or to their teams. The participants shared specific stories and commentary to reflect leaders who served as Awakeners. Becky shared the importance of why a leader should support growth and development, "In my history of being a nurse for the past decade, the most effective leaders I've ever had extended ownership of growth to the team. We were expected to own our growth and the best nurse leaders not only supported us, they facilitated and advocated for us to actually do it". This comment reflects how the Awakener is a motivator, an advocate and a mentor. Leading by example and teamwork were common themes throughout the focus groups. Melinda shared this perspective, "the best leaders I've had over the years were nurses who could work side-by-side with us; my most memorable leader was a 'nurse's nurse,' what I mean is she could do what I did every day, she wasn't just the administrative leader, she was a clinical expert who could be a true resource to the team and to me. She also wasn't afraid to provide feedback on how we could do things better…not just always telling us what was great. She wanted us to grow in our skills and our critical thinking". Melinda's description supports the Awakener as a coach, a motivator and a mentor. Finally, many of the participants vocalized the need for strong nurse leaders to develop and energetically share a vision for the team. Beverly represented this sentiment with her comments, "A good leader needs to have a vision in order to know where the team is going. They need to have an understanding of how to get there and then have good communication skills to get the team on board. We need a captain of the ship with a strong compass and the strong voice to get us sailing in the right direction". Melinda describes the Awakener as an architect who crafts structure and processes that allow the vision to be shared while also energizing the team to experiment and innovate.

3.2 | The Connector

Connecting and community emerged as a consistent and vital aspects of how nurse leaders are effective in creating a culture of trust. The Connector revealed itself in many parallel comments throughout the focus groups with a particular focus on how effective leaders create empowering environments. For example, Elizabeth said, "The leader I would follow to the end of the earth, was all about autonomy. He allowed it, supported it, and expected it. He embraced our ability to come up with the answers to the problems even when he had to go to bat for us with administration. This leader thought of change as a good thing. He hated when someone would say, 'we've always done it this way, so why change now?'" This is just one of many examples illustrating how the Connector embraces change and chaos as an engineer, an edgewalker and a collaborator. Trustworthiness was an area of discussion that brought many participants to become

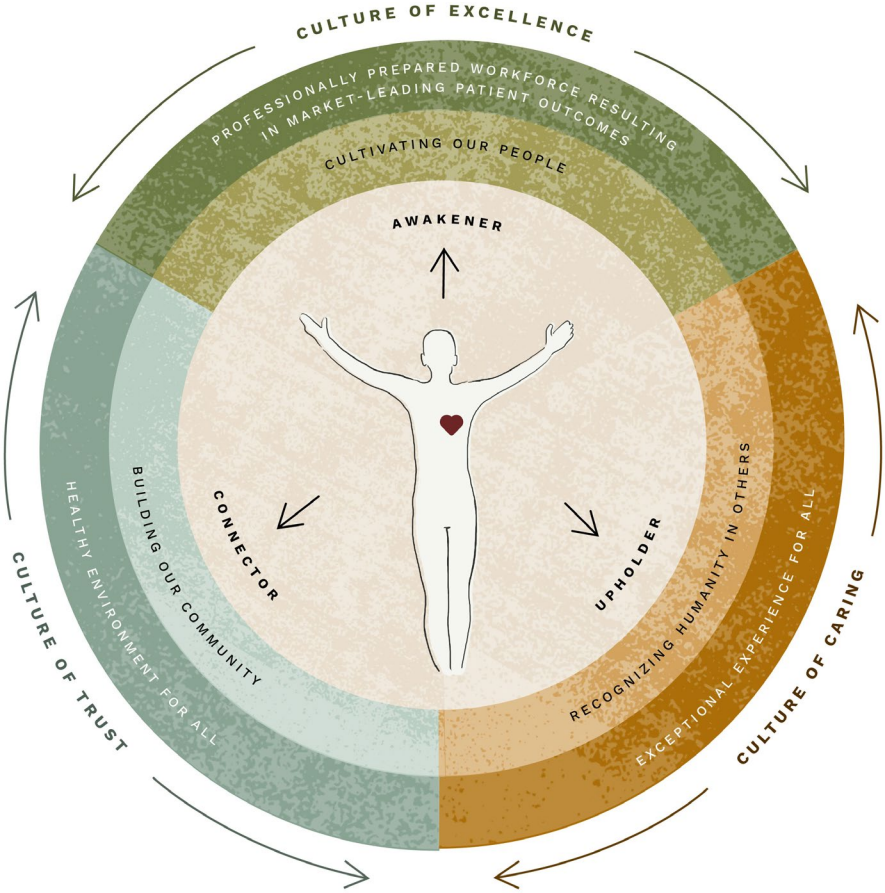

FIGURE 1 Human-centred leadership in health care: The visual framework reflects an innovative approach to leadership in health care that starts with the leader's mind, body and spirit as the locus of influence within local and larger complex systems. The human-centred leader realizes success in connecting leadership attributes of the Connector, Awakener and Upholder to cultures of excellence, caring and trust, which reflect industry-leading metrics (Leclerc et al., 2020)

emotional and vocal in their reflections on examples of ways leaders from their past displayed or failed to display trustworthiness. Karen shared, "leaders have to earn trust and respect. One of the best leaders is the leader I have today. She seeks opinions and actually listens to us. She always follows up by offering choices and honouring and supporting those team decisions. I think the contrast is so apparent because my last leader was the exact opposite. Never saw her. She just handed out 'to do' lists and was the biggest gossip when she did arrive. There was just no trust. It was just a job for us on the team". Karen was able to communicate the value and return on investment when the Connector supports and authentically communicates in the spirit of developing trust and community.

3.3 | The Upholder

Recognizing the humanity in self and others as a means to nurture a culture of caring was prevalent throughout participants' discussions. This portion of the focus group was also consistently the most engaging and time-intensive. It was interesting to note the observations of nearly all participants that leaders who embraced self-care, humility, self-awareness, fairness and kindness towards not just others but to themselves were the most memorable and most effective leaders. Lauren became emotional when she shared this story, "Everybody is going through something outside of work. Could be a loved one who's sick. Could be young kids or older parents to care for. We all have something. The best nurse leader recognizes that work is only one part of life. That leader recognizes that our team is better off if team members are 'healthy' with being able to take care of everything at home first. I had one leader who, from the day I interviewed, said, 'please always let me know how I can support you in taking care of your family first. Family first. Always. You have aging parents and we're here to make sure you can do your best for them. And, trust me, I know if you're worried about them, you won't be your best for us while you're at work". This story, which was echoed by many, displays the Upholder's propensity for being emotionally aware, others-oriented, mindful and socially aware.

4 | DISCUSSION

Theorizing requires multiple vantage points from participants, the data, the literature and the researchers. The goal is for the researchers to see possibilities and establish connections without levying pre-packaged images and automated answers from existing theories or parallel models of thinking (Charmaz, 2014). Another equally important goal of theorizing is to be faithful to the experiences of others, of the participants and of the researchers themselves. The emergence of a contemporary nursing leadership theory provides a

TABLE 2 Advanced Coding Framework for Attributes and Constructs with Definitions

Awakener	Cultivates our people
Motivator	Establishes a learning culture with high expectations for ongoing learning for self and others
Coach	Provides honest feedback, address behaviours inconsistent with learning culture
Mentor	Advises on member accountability for individual growth plans
Architect	Designs structures/processes so innovation can emerge
Advocate	Ensures resources are available for best practice and professional growth
Connector	Builds our community
Collaborator	Unifies others around shared mission and vision
Supporter	Supports, recognizes and appreciates independent problem-solving and individual contributions at the point of service
Edgewalker	Embraces change/chaos by endorsing experimentation of ideas to generate innovation
Engineer	Ensures people are plugged into processes/structures for emergence of new ideas
Authentic communicator	Builds mutual respect and trust through nurturing intentional connections with others
Upholder	Recognizes humanity in others
Mindful	Focuses attention, awareness and energy on present
Others oriented	Supports with respect, kindness, empathy and empowerment
Emotionally aware	Recognizes and embraces humanity at all levels, self-reflective
Socially and organisationally aware	Leads with an open mind
Personally well and healthy	Practises self-care, self-compassion and self-awareness

modern translation of many ways of being we, as nurses and nurse leaders, could only previously sense. The human-centred leadership theory gives voice to nurses in the United States and around the globe to frame their leadership style and action in a way that reflects the essence of nursing.

Reconnecting to the existing literature that provided a foundation for this research, it is clear human-centred leadership departs from popular borrowed leadership styles such as the traditional leader who remains above the system rather than embedded in it (Porter-O'Grady & Malloch, 2018). The traditional leader generally promotes change from top to bottom with a controlling authoritative stance, while the human-centred leader starts with self and recognizes change emanates from the centre of a system outwards (socially and organisationally aware/Upholder). Porter-O'Grady and Malloch (2018) posit a sustainable and successful change rarely comes from the top of any system. Instead, as with the human-centred leadership theory, change begins at the centre of the system and moves to all other parts, influencing everything in the system. No one part determines the change in the whole system. Because of this inner–outward process, outcomes emerge organically via cultures of excellence, trust and caring as is the nature of a complex adaptive system such as health care. If the paradigm is shifted to consider complex adaptive systems with a human-centred leadership approach, those at the point of service are the influential leaders who should be empowered to make decisions pertinent to the care provided.

Another variation between traditional and contemporary theories recognizes the flawed assumption of linear thinking that input into a system will yield a proportional output. In the industrial age, health care was seen as a business and value was given to the quantity of work produced. Porter-O'Grady and Malloch (2018) state the processes associated with the work were seen as almost more important than the purpose of the work. A sense activity was in itself valuable; however, quantity is simply not a differentiator for value (Porter-O'Grady & Malloch, 2018). As nurse leaders race to “do more” and “more” and “more” to improve metrics such as patient satisfaction, leaders find themselves “doing” to the point of burnout and exhaustion. In contrast, the human-centred leader nurtures a safe environment for experimentation of ideas (Edgewalker/Connector) that shares ownership of innovation and change with nurses at all points of service for a healthy work environment and subsequent improved patient and employee outcomes (Architect/Awakener). Finally, examining the focus of each approach using Donabedian's (1966, 2002) quality framework for health care, it becomes clear traditional leadership primarily focuses on outcomes as the pinnacle of success with less focus on the people (structure) or the process. In contrast, the human-centred leader starts with self, focuses outward to the team members (structure), and through consistent application of the constructs of Awakening, Connecting and Upholding (process), cultures of excellence trust, and caring produce the expected metrics (outcomes) (Donabedian, 1966, 2002) (see Table 4).

The borrowed theory of transformational leadership from the business world has provided a foundation for nursing excellence (ANCC, 2015). The unique attributes of a transformational leader focus on strategy around shared vision to influence change within teams and across the organisation. The transformational leadership approach is comprised of four distinct components focusing

TABLE 3 Cross-Reference of ANCC (2015) Magnet Standards with Human-Centred Leadership Constructs and Outcomes

Magnet Outcome Requirement	HCL Component	Culture Change Required
Commitment to culture of safety	Awakener	Culture of excellence
Mentoring plans	Awakener	Culture of excellence
Improve nursing practice environment	Connector	Culture of trust
RN satisfaction: Leadership access and responsiveness	Upholder	Culture of caring
Nurses' involvement in population heath outreach	Connector	Culture of trust
Delivery of culturally and socially sensitive care	Connector	Culture of trust
Nurses and interprofessional groups contribute to strategic goals of organisation	Connector	Culture of trust
RN satisfaction: autonomy, interprofessional relationships, fundamentals of quality, adequacy of resources and staffing	Upholder	Culture of caring
RN to RN teamwork and collaboration/ interprofessional collaboration	Connector	Culture of trust
Decrease in never events/ quality improvement based on EBP	Awakener	Culture of excellence
Advancement of research in nursing/interprofessional	Connector/ Awakener	Culture of trust/ culture of excellence
Decrease in turnover rate	Upholder	Culture of caring
Improved patient experience	Upholder	Culture of caring
Improvements based on patient feedback and service recovery	Upholder	Culture of caring
Increase percentage of nurses certified in their specialty	Awakener	Culture of excellence
Increase percentage of nurses with BSN degree	Awakener	Culture of excellence
Improve patient outcomes secondary to nurses' participation in professional development activities	Awakener	Culture of excellence
Effective transition to new roles	Awakener	Culture of excellence
Individualized professional development plans for nurses at all levels based on performance review, etc.	Awakener	Culture of excellence

TABLE 4 Comparison of Common Leadership Styles in Health Care Using Donabedian's (1966, 2004) Health Care Quality Framework

	Structure	Process	Outcomes
Traditional			x
Transformational		x	x
Servant	x		
Human-centred	x	x	x

on idealized influence, inspirational motivation, intellectual stimulation and individualized consideration, which align with many of the constructs of the human-centred leadership theory. However, there are distinct departures from the current researchers' findings indicating participants' desires to lead and to be led by role models who embody self-care and self-compassion versus idealized influence and charisma. Transformational leaders are effective; however, the transformational leader's emphasis on consensus around shared vision and the organisation's overarching goals and metrics may inhibit individual voice and innovation (Weiss et al., 2019). Transformational leadership is focused top-down with the leader casting the vision and gaining consensus, whereas human-centred leadership uses a centre-outward approach valuing the voice and harnessing the energy and innovative ideas from team members (Engineer/Connector) to create a shared vision (Lin et al., 2019). Also, according to Lin et al. (2019), in transformational leadership, there is a one-way flow of influence from the leader to the employee often resulting in leader emotional exhaustion, burnout and intention to leave the position. In contrast, the human-centred leader provides a safe and open two-way street of input and influence recognizing the health and well-being of both the leader and the team member in the relationship and in the context of meeting individual, unit and organisational goals (Architect, Motivator and Advocate/Awakener). Moreover, in transformational leadership, the organisation is identified as the primary beneficiary of the work through meeting metrics, whereas in human-centred leadership, the foundational complexity framework recognizes and celebrates the individual's contributions and successes in an aggregate effort to reach the goals of the individual, the unit and the organisation (others oriented/Upholder; supporter/Connector; and mentor/Awakener). Finally, transformational leadership is a business-based model focused on process in the one-way influence of leader on team member to produce outcomes, while human-centred leadership embraces the essence of nursing and concentrates on process and people to produce a healthy work environment leading to the expected outcomes (Donabedian, 1966, 2002; Lin et al., 2019) (see Table 4).

Servant leadership is another popular borrowed philosophy employed by many health care leaders. Servant leaders aim to make sure other people's highest priority needs are being served first (Greenleaf, 1977). While this is an admirable philosophy, the focus is squarely on others with little room for self. The experiences of the participants and the researchers themselves indicate an unchecked

focus on others rather than caring for self, results in burnout, stress and unsustainable levels of performance over time. This is the primary concept that sparked the researchers' original interest in a different way of leading. The researchers experienced, firsthand, the psychological and physical effects of long-term servant-first leadership. The human-centred leader, on the other hand, acknowledges the primacy of self-care, self-compassion and self-awareness (mindful, emotionally aware, personally well and healthy/Upholder). Using Donabedian's framework for health care quality as a compass, servant leadership focuses primarily on the structure (people), while the human-centred leader focuses on the people, the process and the outcomes through starting with self and then emanating outward through Awakening, Connecting and Upholding the team members, which leads to the expected outcomes (Donabedian, 1966, 2002) (see Table 4). When the nurse leader is emotionally and physically well, the example speaks volumes to the team members. The premise of the human-centred leadership theory is "it starts with you, but it's not about you".

4.1 | Implications for future research

Future research can test and examine the mechanisms of influence a relational, human-centred theory may have as antecedents to outcomes such as nursing-sensitive indicators, patient satisfaction and RN satisfaction (Wong et al., 2013). Of prime interest would be research to explore the potential relationship between human-centred leadership constructs and attributes with the ANCC (2015) Magnet standards (see Table 3). Just as the borrowed theory of transformational leadership has been shown to align with Magnet standards, it would be of interest to inquire whether a theory specific to nursing and health care leadership would also align or perhaps more closely align with the ANCC standards of excellence. Future research to test the theory of human-centred leadership would aim to be rigorous with multisite recruitment, perhaps comparing leaders and outcomes of Magnet-designated or Pathway- to Excellence-designated facilities with those either on the journey or not designated.

Also, consideration of quasi-experimental or experimental studies with random sampling versus convenience and purposive methods would ensure more rigorous examination of potential causal relationships. Longitudinal versus cross-sectional studies examining multiple points of influence over time would add rigour to the studies to show sustained effects. Also, testing the theory in diverse settings across acute care and outpatient settings would examine the generalizability of the theory. Finally, the human-centred leadership theory would be well suited for testing in other health care disciplines including medicine, physical therapy, pharmacy, social work and administrative teams.

4.2 | Implications for nurse leaders

The connection between nursing leadership and patient outcomes and whether a relationship exists is the million-dollar question. In a systematic review of 20 research studies examining connections between nursing leadership and patient outcomes, Wong et al. (2013) found relational-type leadership styles have a positive relationship with patient satisfaction and improved patient safety outcomes. There were no nursing or health care-specific leadership styles within Wong, Cummings, and Ducharme's review; however, human-centred leadership aligns with the characteristics of a relational leadership style. Based on the results of our research and the constructivist grounded theory approach rooted in participants' experience, decades of researchers' perspectives and the literature, there are potential connections (positive or causal) between the attributes and constructs of a human-centred leadership approach and industry outcomes (cultures of excellence, trust and caring).

Nurse leaders at all levels would be uniquely served by using a leadership style customized and rooted in the essence of nursing. The participants in the focus groups were energized to be part of a study to produce a nursing-specific leadership theory. They described how using borrowed theories gets the job done but misses something in the end. The missing link was described by participants as the apparent mismatch of the "humanity of our role to care for people when they're at their most vulnerable and the current trend to push harder and harder to meet numbers". A human-centred approach recognizes the need to balance recognition of humanity in nurses and patients alongside the creation of a culture that organically leads to the desired organisational metrics. Leaders who cast a vision for nurses, their patients, their units, and their hospitals should start with themselves and pay attention to self-compassion, self-care and self-awareness because each leader not only sets the example, but also sets the pace for health and well-being of their teams. From there, the leader can naturally influence change from the inside out by operationalizing the attributes of an Awakener, Connector and Upholder (Leclerc, Kennedy, & Campis, 2020; Porter-O'Grady & Malloch, 2018). The theory of human-centred leadership proposes desired metrics will organically follow the movement of a human-centred leader (see Table 3).

Nurse leaders should also consider taking part in a revolutionary movement to validate this nursing-specific leadership model by using the human-centred leadership theory as a framework to test relationships between nursing leadership and outcomes. Nursing is 3.8 million members strong and remains the largest part of the health care workforce in the United States and the world (Smiley et al., 2018). The profession and the world are primed for a nursing-specific leadership theory.

4.3 | Strengths and limitations

Strengths of the research lie in the attention and respect paid to the rigour of the constructivist grounded theory approach. The researchers were vigilant in establishing validity through measures to ensure trustworthiness: credibility (member checks, engagement

over time with multiple participants, different data sources); transferability (detailed narrative notes, field notes, contextual participant voice); and confirmability (data trail) (Lub, 2015; Pratt, Kaplan, & Whittington, 2020). While rigorous in methodological approach, there are a few limitations. Despite initial thematic and subsequent theoretical saturation with participants from multiple organisations, the sample was limited to acute care. Generalizability will be enhanced with future testing of the theory within diverse settings. Finally, the researchers recognize the challenges that come with a new theory. One such challenge is the development of accompanying tools to aid utility of the theory in practice. The researchers are in the initial stages of psychometric testing of an assessment tool to complement the theory. The purpose of an assessment will allow leaders at all levels to gauge strengths among the three constructs of Awakener, Connector and Upholder. The assessment will include a supplement to guide the leader in techniques and strategies to strengthen those weaker constructs.

5 | CONCLUSION

Nursing represents the largest segment of the workforce in the nation and in health care and is the most trusted profession for 18 years running (American Nurses Association, 2020; Smiley et al., 2018). Nurse leaders influence patient care, safety and outcomes in addition to cultivating the future of the profession, our new nurses. Nurse leaders have had to borrow theories from the business world because a contemporary leadership theory does not exist in nursing or in health care. Through the constructivist grounded theory process, it became clear nursing does indeed have a unique leadership style employed by many nurse leaders. It is the leader our participants would follow to the end of the earth. It is the leader who balances accountability and metrics with self-care and an outward focus. It is the leader who recognizes humanity in all team members while being mindful and present and expecting the same of the team. It is the leader who awakens excellence in team members by coaching and mentoring within a framework of setting a high bar for performance and expecting the team to deliver. It is the leader who courageously walks the edge of change, embracing chaos and experimentation of innovative ideas while ensuring safe boundaries for the team to execute their dreams. Human-centred leadership is a theory, a philosophy and, ultimately, a movement that will unify nursing around a shared vision to live and breathe the essence of nursing in the way our hearts already know and crave to return to. Human-centred leadership will allow nursing to achieve human-centred health care. Its time has come.

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CONFLICT OF INTEREST

The authors declare no conflict of interest, that is financial, consultant, institutional or other.

ORCID

Lucy Leclerc https://orcid.org/0000-0002-5825-0307
Kay Kennedy https://orcid.org/0000-0001-7356-4948

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