NURSE-LEADER CONSTRUCTION PROCESS BARRIERS: AN ETHNONURSING BARREIRAS DO PROCESSO DE CONSTRUÇÃO DO ENFERMEIRO-LÍDER: UMA ETNOENFERMAGEM

BARRERAS DEL PROCESO DE CONSTRUCCIÓN DEL ENFERMERO LÍDER: UNA ETNOENFERMERÍA

Liliane Alves Pereira¹, Carolina Domingues Hirsch², Rosemary Silva Silveira³, Jamila Geri Tomaszewski Barlem⁴, Claudia Denise Schalenberger⁵, Edison Luiz Devos Barlem⁶

ABSTRACT

Objective: to understand the barriers in the nurse-leader building process. **Method:** a qualitative study, based on the presuppositions of the ethnographic study, having, as the subjects, 22 professionals of the Nursing team that compose three work shifts. The data analysis respected what was recommended by the ethnographic survey, which proposes that the information be analyzed in four phases using specific and congruent criteria with the qualitative paradigm and presenting the results after each phase. **Results:** were grouped in two categories: Personal characteristics and Institutional Culture. **Conclusion:** the main barriers in the construction of leadership by the nurse must be recognized to be overcome in the daily practice, since both personal characteristics and institutional culture must be transposed with knowledge and creativity. **Descriptors:** Nursing; Leadership; Ethics; Methodology of nursing research; Organizational culture; Health.

RESUMO

Objetivo: compreender as barreiras no processo de construção do enfermeiro-líder. **Método:** estudo qualitativo, fundamentado nos pressupostos da etnoenfermagem, tendo, como sujeitos, 22 profissionais da equipe de Enfermagem que compõem três turnos de trabalho. A análise dos dados respeitou o preconizado pela etnoenfermagem, que propõe que as informações sejam analisadas em quatro fases utilizando-se de critérios específicos e congruentes com o paradigma qualitativo e apresentando os resultados após cada fase. **Resultados:** foram agrupados nas categorias *Características pessoais* e *Cultura Institucional*. **Conclusão:** as principais barreiras na construção do exercício da liderança pelo enfermeiro devem ser reconhecidas para serem superadas no cotidiano do exercício profissional, pois tanto as características pessoais, quanto a cultura institucional devem ser transpostas com conhecimento e criatividade. **Descritores:** Enfermagem; Liderança; Ética, Metodologia de pesquisa em enfermagem; Cultura Organizacional; Saúde.

RESUMEN

Objetivo: comprender las barreras en el proceso de construcción del enfermero líder. **Método:** estudio cualitativo, fundamentado en los presupuestos de la etnoenfermería, teniendo, como sujetos, 22 profesionales del equipo de Enfermería que compone tres turnos de trabajo. El análisis de los datos respetó el preconizado por la etnoenfermería, que propone que las informaciones sean analizadas en cuatro fases, utilizando criterios específicos y congruentes con el paradigma cualitativo, presentando los resultados después de cada fase. **Resultados:** se agruparon en las categorías: 1) Características personales y 2) Cultura Institucional. **Conclusión:** las principales barreras en la construcción del ejercicio del liderazgo por el enfermero deben ser reconocidas para ser superadas en el cotidiano del ejercicio profesional, pues tanto las características personales, en cuanto a la cultura institucional deben ser transpuestas con conocimiento y creatividad. **Descriptores:** Liderazgo; Ética, Metodología de investigación en Enfermería; Cultura de la Organización; Salud.

¹Master (PhD student), Postgraduate Program in Nursing, Federal University of Rio Grande / UFRS. Santa Maria (RS), Brazil. E-mail: irililiane7@hotmail.com ORCID iD: <https://orcid.org/0000-0001-6354-7781>; ^{2,3,4,6}PhDs, School of Nursing, Federal University of Rio Grande / UFRS. Santa Maria (RS), Brazil. E-mail: hirsch.carolina@gmail.com ORCID iD: <https://orcid.org/0000-0002-5220-0229>; E-mail: anacrol@mikrus.com.br ORCID iD: <https://orcid.org/0000-0003-0671-0022>; Email: jamila_tomaszewski@hotmail.com ORCID iD: <https://orcid.org/0000-0001-9125-9103>; E-mail: ebarm@gmail.com ORCID iD: <https://orcid.org/0000-0001-6239-8657>; ⁵Master (egress) Federal University of Rio Grande / UFRS. Santa Maria (RS), Brazil. E-mail: deniseschal@yahoo.com.br ORCID iD: <https://orcid.org/0000-0003-0713-6165>

INTRODUCTION

The term leadership has its etymological origin in the English *Laedan*, which means the one that guides or leads. However, this meaning is considered obsolete, given its paradoxical constitution by similarly comparing the terms *guide* and *lead*. The concept of leadership has evolved historically, progressing from the schools of thought and extending its theoretical knowledge from authoritarian leadership, directed exclusively to the leader, to the emergence of a leadership that considers individuals and the environment in a process of influence on the concept and / or exercise of leadership.¹

Although the idea of leadership has existed since the Christian era, considered as old as writing, the term leadership has been used for the first time in a study related to business schools aiming to understand how different people behave when they are governed by different administrators.² In general, leadership can be conceptualized as an ability to influence people in pursuit of common goals, inspired by a collective policy, as an ideal pursued in social, political, economic, family, business and service providers. In the same sense, hospital environments that see leadership as an essential tool to guarantee the achievement of excellence, stand out.³

The transformations that occurred in health environments, influenced by the constant changes in the social scenario and the health demands and necessities, have made Nursing a propeller of ethical and humanized care, in keeping with the new configuration of care needs. This requires professionals to be more flexible and broader in their vision of the reality that surrounds them, as well as the professional improvement in order to dominate new skills and abilities, among them, the daily construction of leadership.³

The leadership style that is in vogue is the transformational one, style that tends to involve the leaders in the decision making in order to recognize that the human being carries in him/her values, beliefs and cultures that can be of great value for the development of the Institutions. This style is based on human values, as a basis for their development, combining the capacity to motivate and influence people with the personal potential of each individual, constructing a joint decision making with shared results.⁴

Leaders have an engaging charisma, capable of encouraging their followers to go in search of their desires, so that they can grow

individually and collectively, directing their actions for the good of the team, internalizing the common goal and achieving the expected results.⁵ Under this view, the Nursing leadership is a process of personal construction that requires skills for effective interpersonal relationships, joint decision-making, and co-responsibilities based on the premise of respect for individuals under their command.⁶

It is in this complex panorama that the nurse can find barriers to the exercise of leadership, since the environment and the interrelationships can derive numerous elements that hinder or prevent the establishment of leadership.³ In light of the above, this article aimed to understand the barriers present in the the construction process of the nurse-leader, justifying the need to understand the barriers that impede the construction of leadership in nursing professionals, given their importance for the expansion of qualified health actions that are in keeping with the new demands and social realities.

OBJECTIVE

- To understand the barriers in the nurse-leader construction process.

METHOD

This is a qualitative study, based on the ethnographic survey, which is anchored in assumptions of ethnography adapted for the study of nursing phenomena. In this way, the ethno-inference is defined as the analysis of the nursing phenomena considering the people's point of view, their beliefs, values, culture, visions of the world and each individual's way of being.⁷ The study was composed of nine stages, according to the what ethnonursing shows, divided into: four observation phases; one, interview and four phases of analysis. The observation phases are divided in observation without interference, with interference, with active participation and with reflexive observation, these being concomitantly analyzed.⁷

This study was developed in a clinical unit located in a philanthropic hospital in the South of the country with a capacity for 43 beds and with a service profile exclusively by the Unified Health System (UHS). Twenty-two key informants were selected, five nurses, 16 nursing technicians and one nursing assistant. The general informants were all those who interacted with the work environment, influencing, directly or indirectly, the actions / attitudes of the nurses, totaling 51 subjects. Observations occurred from July to November

2015 for a total of 24 work shifts for a total of 65 observation hours. Then, the interviews were carried out, which occurred in the period from November to December and ranged from 45 minutes to two hours in duration.

The inclusion criteria of the key informants were: to be in the work environment during the observation and interview phases and, after the first observation phase, to reveal leadership attitudes/actions in the dialogue, communication with team members or in the decision.

The observations were carried out with a focus on the daily activities of the professionals, in their relationship with patients, family members, companions, co-workers, administration and support services, focusing on how nurses exercise leadership in the work environment with different actors in the care process.

After phases one and two of the observation, it was possible to develop a semi-structured interview guide in which questions were formulated to guide discussions about the barriers of the nurse-leader building process. The interviews began with the third phase of the observation, with the objective of improving the data collected during the observations, correcting possible flaws and clarifications and giving greater security and reliability in data collection and analysis.⁸

The data analysis respected the one recommended by the ethnographic survey, which proposes that the information be analyzed in four phases using specific criteria and congruent with the qualitative paradigm. The divisions used in the four phases of ethno-culture are educational, because the process occurs in an overlapping and overlapping way, respecting the dynamics of coming and going and causing phases to pervade and are constantly confronted.⁹

At the participant observation stage, the gaze was focused more on interventions, but never losing focus on observation, engaging with informants to learn more about their culture. Then, the second phase of the

analysis and the first phase of the interview were started with the intention of discovering the actions, attitudes and behaviors that express the construction of the nurse-leader. In the third phase, the interviews were analyzed and the most significant themes were sought among those that were addressed. In the fourth phase, the researcher made reflexive observations evaluating the information found.⁸ The fourth phase consisted of the synthesis of data, the abstraction of categories and theoretical formulations, the synthesis of thought, abstraction and discovery of important themes, with the analysis of the previous phases.

The ethical aspects were respected, and this study was approved in the local ethics committee under opinion number 07/2015. In order to preserve the anonymity of the informants, the statements are presented using the letters E, T or A, to describe nurses, nursing technicians or nursing assistants, followed by Arabic numeral referring to the order of the interview.

RESULTS

Based on the analyses, it was possible to understand the barriers that are present in the nurse-leader construction process, imbued with personal characteristics that permeate values, personal and professional (mis) commitment, generating dissatisfied relationships and transmitting a positive and coherent professional image, to an institutional culture that blames the nurse for activities that are not their own, with the responsibility of developing high demands for work without adequate human and material resources. After analyzing the data, two categories related to the barriers present in the nurse-leader construction emerged: personal characteristics and institutional culture.

Figure 1. Nurse-leader construction process barriers

◆ **Personal characteristics**

This category presents itself as a connection between the barriers present in the construction of leadership by the nurse and their personal characteristics, understood as influencing the exercise of leadership, since these characteristics involve the nurse's motivation. The main barriers faced by professionals in the practice of leadership are related to *professional and personal disengagement, difficulty in relationship, lack of professional competence and knowledge, and lack of creative management skills.*

When observing the daily routine of the nursing team professionals, it was possible to perceive that, often, the team's performance reflects the lack of a leadership characteristic on the part of the nurse. Many observations present the technical team as professionals with little commitment to the care and assistance that should be provided to the patient due to the personal characteristics or the absorption of the organizational culture. *Does the lady (caregiver) know how to remove the serum? ... No? Then close the serum I'm going to remove it, I'll get there. This way, I do not finish my medication today. They call all the time here ... it's difficult.* (T1)

The professional, who assumes the task of delegating tasks to the companions and patients, can not perceive that Nursing care involves care actions ranging from direct activities to indirect activities and that no doing of their competence should be minimized or overlooked. The delegation of basic activities of the profession trivializes and fragments Nursing care, which disperses and becomes invisible in care settings: *We still have not been able to solve the companion*

inconveniencing. Disrespect sometimes. I think it's awful. The presence of the companion makes the process of care difficult. (T2)

From the above, it is possible to perceive the inability of the team to recognize the role of the companion in the care of the patient, allowing the observation that the personal characteristics of these professionals promote an atmosphere of relational difficulties preventing the nurse to grow as a leader. *There is no union, I think this part is very difficult. The hospital is experiencing difficulties, and it's not just here, but in any city. I think this is a detail to which people are clinging and, even if you did not have that difficulty, there were these problems (relationship), so I think the team is "each one by itself", without any help of a leader.* (T3)

For leadership to be effective, there must be dialogue and communication through establishing a bond of trust in the pursuit of common goals. Therefore, it is necessary for the nurse to be present in the daily life of the difficulties experienced by the team, working situations that impact the development of the professionals, through the reception and respect among the members of the team. *We respect because you have to respect the culture and the limits of others, but also, we will impose our way as long as they respect his limit and mine.* (E1)

When feeling incapable of dealing with the differences present in the interaction environment, the nurse can not establish a plan of action that achieves the idealized goal, being perceived by the team as an immature professional, because they can not manage the situations where there are divergences of opinions. *I think I do not feel empowered to solve certain problems because I*

think there is a lot of this oversight (supervisory nurse) thing, even though I think they are not helping. They play their part, but as supervision, they are leaving much to be desired. (E2)

Too often, lack of understanding of what it is to be a leader makes the exercise of leadership non-existent, confusing, or even authoritative for both the nurse and the staff. This distortion fuels a blurred, vertical and imposed professional image, believing that leadership is an imposing and unilateral attribute with the purpose of decreeing actions and behaviors. *The fact that they are no longer able to impose themselves, this hinders the leader. I think that's it, the thing of the person to impose ... You have to do it there and you do ... It is not to go in fear, you know ... Of the person getting hurt. There is no such thing there. If you're leading, I have to respect you. (T4)*

The view of leadership as an unquestionable authority leads nurses to find creative ways of dealing with the team, to make them understand that the leadership process can not be linked to authoritarianism, or even to imposition, since in this way, leadership is not exercised, but rather the authority established by virtue of the position. *I neglect a lot, mainly bureaucratic stuff, that I leave behind. I think it was for me to do more meetings, to talk more, but that's why I'm very much in the care part. I see that the team is overloaded, so I keep running to help and I end up not doing the Nursing records. (E1)*

When personal motivations can not be consistent enough to support the importance of leadership in an industry, the environment and its institutionalized culture will eventually override the individual by imposing pre-established routines and actions on the individual. When the nurse becomes unaware of their role as leader, the Nursing team develops mechanisms to minimize nurses' lack of care through their undervaluation. This disbelief of their image and role of leader requires the nurse's motivation and creative ability to present their work as essential in the care and organization of the environment.

◆ Institutional culture

This category presents the interfaces between the barriers present in the construction of the nurse leader and the institutionalized culture in care settings, since leadership can only be exercised if it is inserted in an environment of sociocultural context. In this way, the environment can become a barrier to the exercise of leadership through the imposition of duties and functions that do not relate to the nurse; the existence of high demand and workload and the lack of materials and human resources that result in a disorganization of the health team and, consequently, a discontinuity in care.

Nurses should take a position of reference in their work environment so that care can be fully implemented, since often the nurse's inability to position herself in a strong manner can generate work overload, since this professional ends up taking on relevant responsibilities to other professionals: *I have a prescription that is unsigned and stamped. Okay, I'll wait. The doctor is already going up to sign that prescription and I go to the pharmacy to get what is missing because otherwise, then, they say I went on duty missing something. (E4)*

All the professionals have their duties defined in the hospital environment, which allows each one to be responsible for the care in a way that is consistent with their competencies. However, Nursing professionals often have high demands and workloads due to the absorption of tasks that do not relate to them, preventing them from being able to exercise their leadership consistently.

The immediate resolution of "shortcomings" produces, in these professionals, a kind of blindness to the incoherences of the organizational environment leading, progressively, to frustration and diminishing the link between leadership and care. Linked to this, there is a lack of materials and inputs, which in nurses causes the need for dialogue, coping and conflict management, which in themselves are not bad for the exercise of leadership, but when they become a constant in the institution, they become harmful to the leader and the entire health team.

There are some medications that are missing: ciprofloxacin, metronidazole ... Nasoenteric probe, number 12, does not have ... There's only one 08, but I think it's clogged ... I can not take any more medication. (E5)

There is no serum of 100 ml, no serum of 250 ml, no serum of 500 ml ..., nor danulas, nor nasoenteric probe. (T5)

The lack of inputs and materials causes the environment to become tense, conflicting and leads to disarray showing the differences and difficulties of integration between the team members. From this perspective, the nurse-leader ends up directing his/her actions exclusively to solve the needs and immediate demands of the sector. *I've called all the units, there are no vital signs in any sector. So we're going to have to adapt. None at all. The sectors are using evolution sheet, there is nothing to do. (E4)*

The doctor wanted me to do a direct antibiotic, I had to tell him it could not be like that. He claimed that he does not have the IM in the hospital and, in order not to make a central access, he did the EV himself. I put my foot down and said no and we waste time with it, but I will not do it. (E1)

This disorganization of the sector, linked to the search for superficial and immediate resolutions of conflicts, shows a Nursing that can not perceive itself as a sequential profession, which does not give continuity to the work of the other, understanding the profession in a dissociated way. In this context, the nurse does not engage and does not involve the team in a sense of leadership and continuous education reflecting the lack of direction of the team. *In all the experience time I have, I see the same situations. There is always a conflict, always, like this: "Ah, you did not because you did not want to." If I come to a colleague and say, "Oh, it could not be done, I'm passing it on to you" creates discomfort. So sometimes we do not even say it. I think there is some restraint among people, but I see it's the Nursing routine.* (T6)

She always complains when we're on duty. I thought she was picking on me. Then one day I said, "Nursing is continuity. How many times have I had your back, and I will not be talking about it." (T7)

The institutionalized culture is being introjected into the life of the nursing professional who, progressively, loses the basic defining characteristic of their training: The care. When the institutional culture produces a nurse who does not press for the good of her collaborators, legitimizing actions and attributions that are not consistent with the nurse's doing, the result will always be disorder, conflict and discontinuity in care.

DISCUSSION

The barriers experienced by nurses in the construction of leadership bring, in their place, two distinct but complementary realities: personal characteristics as a significant condition in the process of constructing the leader and institutional culture, where the work environment tends to direct the actions and attitudes of professionals within the objectives, mission and institutional values.⁹

Personal characteristics are based on the values, beliefs, culture and customs of each person, being the basis of all the decisions that the human being takes throughout life.¹⁰ These are the characteristics that motivate nurses to act in a way that is consistent with what is proposed and expected of them as a professional and human being, defending their ethical-moral values as well as their personal beliefs during their professional life. However, in the daily life of the profession, actions and attitudes emerge that demonstrate an apparent personal and even professional disengagement with the reality that surrounds it, leading to an action that disregards the

predefined responsibilities of health professionals.¹¹

When the nurse, in the exercise of leadership, presents themselves as indifferent to the realities that surround them, they tend to infect the whole team in the same way, making it impossible to integrate doing in order to reach the proposed goal. This attitude hinders the relationship between teams and professionals, as well as with the institution itself, because the leader is someone who, in recognizing weaknesses, must establish assertive communication and frank dialogue.¹²

This difficulty of relationship, based on the lack of commitment of the leader, expresses that the support of his leadership exercise is not well defined, since the leader is only recognized as such if they are able to converge the objectives, relationships, interactions and associations between those involved in the care process.⁹

Thus, the nurse can confuse leadership with authoritarianism, guiding the relationship in the power of command and obedience at any cost, disregarding mutual respect and trust in the development of doing.¹³ In this reality, the nurse-leader becomes a repudiated by the team, oppressor of those involved in the care, constructing an image of someone unable to deal with the different or to dialogue in the face of an opposition situation.¹³

The professional image of an authoritarian or difficult-to-communicate nurse expresses the lack of competence to deal with the new, with the different, constructing a paradoxical image where the attempt to be strong, through a tax posture, leads to the unveiling of weaknesses and weaknesses as the leader of a team. However, this lack of competence in leadership transcends the space of interpersonal relationships leaving the team without reference and / or direction in decision making.¹⁴

From a corrupted image of being leader, the nurse ends up developing their team management activities inefficiently and ineffectively depersonalizing the nurse's idea as a reference professional in their work environment. This reality becomes an obstacle to the exercise of leadership, since neither the professional nurse can clearly define what their role in the environment and how important it is to the institutional setting. Consequently, this lack of leadership profile entails a creativity deficit to overcome crises or to point out new paths or even redirect actions on the institutional culture.¹⁵⁻⁶

Just as the professional attitude adopted by the nurse reflects in the care environment, the institutional culture, in turn, also exerts a unique influence on the process of construction of the nurse-leader, having clear objectives and sufficient resources that allow the nurse, improve their daily actions as a leader. Often, the organizational culture assigns to the nurses tasks that are not their responsibility, generating overload and frustration to this professional, since the latter can not perform their functions in a coherent way, giving up their time to perform duties that are of others categories. In this way, the nurse-leader must be clear of their duties by actively engaging in these inconsistencies and not being conniving or blaming both himself and the team for an activity that must be carried out by other professionals.¹⁴

Linked to this, there are, in the institutional culture, high demands and workloads that, over time, can become legitimized by institutions leading to dissatisfaction in the work environment. These high demands, coupled with high workloads, mean that the leader is not able to define paths to be followed by the team fixing their actions in short-term and inefficient resolutions.¹⁷

The high demand and the work load reveal the deficient structure for the accomplishment of the actions and activities of the nurses, being more strongly evidenced in the lack of human resources. When the quantitative staffing factor becomes evident, the nurse-leader's construction process is impaired, since the job demand does not allow an effective dialogue with the team, just as the sharing of their desires does not occur due to the lack of time to share decision-making.³

Added to this is the lack of material resources and inputs that causes the nurse leader a constant search for resources that allow to offer a minimally dignified and humanized assistance in the attempt to establish, with the team, a relationship of unity that motivates to work for health. However, leadership is not an action practiced at a specific time for problem solving, it is part of the daily routine of doing, and when the environment is not conducive to this practice, the daily construction of the nurse leader is weakened by inadequate subsidies for their development and maintenance.¹⁸

The lack of human resources, materials and supplies causes a disorder in the work environment leading to a progressive demotivation that can lead to disconnected

actions and even inconsistent with the goal of care. This complicates the nurse-leader's construction process because it does not combine the organizational climate with the motivations of the leaders in the pursuit of the desired ideals.¹⁵⁻⁹

In an environment of demotivation, the presence of the discontinuity of care is clear, since care is an action that unites science and art, the technical doing and a humanized doing that respect the individuality of the subject with human actions and attitudes that reflect the wishes of those entrusted to the care team.²⁰

The fragility in the leadership-building process, caused by institutional culture, entails a disorganization of the team producing a distorted view of the nurse's actions and a disbelief of the leader's role and leadership by the team. Thus, the disorder of the team is a reflection of the insecurity caused by the environment and a dissatisfaction of the professionals in the exercise of their profession, data that make impossible the construction of a leader when the institution does not offer subsidies for the convergence between the power of the leader to influence the team and the motivation of those who are led to act towards the common objective.

When nurses recognize their actions in the light of ethical conduct, frank dialogue and clear communication, they are more protected from these barriers faced in the exercise of leadership. In this sense, by strengthening this professional's perspective with a clear role in the performance scenario, placing themselves as the protagonist of care, they become able to guide all individuals involved in this process and foster, in the Institution, actions and projects capable of minimizing the barriers presented in the exercise of leadership.¹⁹

CONCLUSION

Knowing the barriers present in the construction of leadership in Nursing stimulates professionals to overcome, since both personal characteristics and institutional culture are barriers that must be transposed with knowledge and creativity since this process is a continuous search for the professional being able to act in favor of the changes that are necessary to make it compatible with the ethics of humanized care.

Understanding the barriers to the exercise of leadership by the nurse offers directions for coping with situations that may hamper the work context by overcoming them in an innovative way. In this sense, scientific

knowledge is an essential and motivating element in the search for professional growth, making Nursing an increasingly solid and resistant profession.

The limitations of this study lie in the fact that it was carried out with a specific sample of Nursing professionals working in a single sector of an Institution in the extreme south of Brazil.

REFERENCES

1. Silva ASMR, Penão JLP, Pereira JN, Joviliano RD. Leadership, motivation and organizational environment in humanization Rev EPeQ/Fafibe on-line [Internet]. 2013 [cited 2015 Nov 18];5:56-64. Available from: <http://unifafibe.com.br/revistasonline/arquivos/revistaepqfafibe/sumario/27/05022014171938.pdf>
2. Silva JB. Evolution of Leadership and Posture of the Current Leaders. UNOPAR Cient Ciênc Juríd Empres. 2014 Mar;15(1):119-27. Doi: <http://dx.doi.org/10.17921/1517-9427.2014v15n1p%25p>
3. Pereira LA, Primo LS, Tomaschewski-Barlem JG, Barlem ELD, Ramos AM, Hirsh CD. Nursing and leadership: perceptions of nurse managers from a hospital in southern Brazil. J Res Fundam Care Online. 2015 Jan/Mar;7(1):1875-82. Doi: 10.9789/2175-5361.2015.v7i1.1875-1882
4. Bamford-Wade A, Moss C. Transformational leadership and shared governance: an action study. J Nurs Manag. 2010 Oct;18(7):815-21. Doi: [10.1111/j.1365-2834.2010.01134.x](http://dx.doi.org/10.1111/j.1365-2834.2010.01134.x)
5. Keskes I. Relationship between leadership style sand dimensions of employee organizational commitment: a critical review wand discussion of future directions. Intangible Capital. 2014;10 (1):26-51. Doi: <http://dx.doi.org/10.3926/ic.476>
6. Eneh VO, Vehviläinen-Julkunen K, Kvist T. Nursing leadership practices as perceived by Finnish nursing staff: high ethics, less feedback and rewards. J Nurs Manag. 2012 Mar; 20(2):159-69. Doi: [10.1111/j.1365-2834.2011.01373.x](http://dx.doi.org/10.1111/j.1365-2834.2011.01373.x)
7. Leininger M. Ethnomethods: the philosophic and epistemic bases to explicate transcultural nursing. J Transcult Nurs. 1990;1(2):40-51. Doi: [10.1177/104365969000100206](http://dx.doi.org/10.1177/104365969000100206)
8. Leininger M. Teoria do cuidado transcultural: diversidade e universalidade. In: I Simpósio Brasileiro de Teorias de Enfermagem. Anais do I Simpósio Brasileiro de Teorias de Enfermagem; 1985; Florianópolis: UFSC; 1985. p. 255-76.
9. Santos E. Gestão e liderança: uma necessidade de transformação comportamental. RIT - Rev Inovação Tecnológica [Internet]. 2013 [cited 2017 Nov 25];3(1):86-96. Available from: <http://rit.faculadeflamingo.com.br/index.php/publicacoes/issue/archive>
10. Phillips N, Byrne G. Enhancing frontline clinical leadership in an cute hospital trust. J Clin Nurs. 2013 Sept; 22(17-18):2625-35. Doi: [10.1111/jocn.12088](http://dx.doi.org/10.1111/jocn.12088)
11. Costa DG, Dall'agnol CM. Participative leadership in the management process of nightshift nursing. Rev Latino-Am Enfermagem. 2011 Nov/Dec;19(6). Doi: <http://dx.doi.org/10.1590/S0104-11692011000600005>
12. Zampieron A, Spanio D, Bernardi P, Milan R Buja A. Nurse managers preferred and perceived leadership styles: a study at an Italian hospital. J Nurs Manag. 2013 Apr; 21(3):521-8. Doi: [10.1111/j.1365-2834.2012.01358.x](http://dx.doi.org/10.1111/j.1365-2834.2012.01358.x)
13. Wang X, Chontawan R, Nantsupawat R. Transformational leadership: effect on the job satisfaction of Registered Nurses in a hospital in China. J Adv Nurs. 2012 Feb;68(2):444-51. Doi: [10.1111/j.1365-2648.2011.05762.x](http://dx.doi.org/10.1111/j.1365-2648.2011.05762.x)
14. Maboko DR. Nursing leadership in an academic hospital in Gauteng. J Nurs Manag. 2011 Oct; 20(7):912-20. Doi: [10.1111/j.1365-2834.2011.01336.x](http://dx.doi.org/10.1111/j.1365-2834.2011.01336.x)
15. Silva VLS, Camelo SHH, Soares MI, Resck ZMR, Chaves LDP, Santos FC, et al. Leadership practices in hospital nursing: a self of manager nurses. Rev Esc Enferm USP. 2017;51:e03206. Doi: <http://dx.doi.org/10.1590/s1980-220x2016099503206>
16. Moura GMSS, Inchauspe JAF, Dall'Agnol CM, Magalhaes AMM, Hoffmeister LV. Expectations of the nursing staff in relationship to leadership. Acta Paul Enferm. 2013; 26(2):198-204. Doi: <http://dx.doi.org/10.1590/S0103-21002013000200015>
17. Leininger M, Farland Mr. Transcultural nursing: concepts, theories, research & pratice. 3rd ed New York: McGraw-Hill; 2002.
18. Amestoy SC, Backes VMS, Trindade LL, Canever BP. Producción científica sobre liderazgo en el contexto de la enfermería. Rev Esc Enferm USP. 2012 Feb; 46(1):227-33. Doi: <http://dx.doi.org/10.1590/S0080-62342012000100030>
19. Wong CA, Laschinger HK. Authentic leadership, performance, and job satisfaction: the mediating role of empowerment. J Adv Nurs. 2013 Apr;69(4):947-59. Doi: [10.1111/j.1365-2648.2012.06089.x](http://dx.doi.org/10.1111/j.1365-2648.2012.06089.x)

Pereira LA, Hirsch CD, Silveira RS et al.

Nurse-leader construction process barriers...

20. Balsanelli AP. Leadership in nursing: Challenges and possibilities. Acta Paul Enferm. 2017 Jan/Feb; 30(1):3-4. Doi: <http://dx.doi.org/10.1590/1982-0194201700001>

Submission: 2018/11/05

Accepted: 2018/03/18

Publishing: 2018/05/01

Corresponding Address

Liliane Alves Pereira

Rua dos Andradas, 1614

CEP: 97010-32 – Santa Maria (RS), Brazil