An understanding of nurse educators’ leadership behaviors in implementing mandatory continuing nursing education in China

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Summary Mandatory continuing nursing education is viewed as one way to develop registered nurses’ continuing competencies. However, as has been argued internationally, it can also create a paradox in terms of learning to meet study requirements. Such paradox has been discussed in China since the implementation of mandatory continuing nursing education in 1996. Nurse educators, who develop continuing nursing education programs, appear to respond to the paradox differently associated with their leadership styles. This article reports a qualitative study aiming to gain an understanding of nurse educators’ leadership behaviors in implementing mandatory continuing nursing education in China. Gadamer’s philosophical hermeneutics underpins in-depth interviews with five nurse educators and data interpretation. Two categories of nurse educators, described as proactive educator and reactive educator, were identified and compared with two types of leadership styles described as transformational leader and transactional leader in the literature of educational leadership and continuing professional development. Proactive educators shared core attributes of transformational leaders and were able to relieve the paradox in mandatory continuing nursing education. Reactive educators however showed some attributes of transactional leaders and might escalate the paradox. Findings suggest further research in relation to the preparation of nurse educators.

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Introduction

Mandatory continuing nursing education (MCNE) was instituted in China in the context of healthcare reform for the delivery of a low cost, easy access...
and high quality health care service (Chinese Ministry of Health, 2000). However, as has been argued internationally, MCNE creates an inherent paradox between learning for competence and learning to meet credit requirements (Carpenito, 1991). This paradox also appears in China and manifests as learning for gaining credits, buying or selling credits, and supplying irrelevant programs for marketing profit (Han, 2004; Lu, 2004). Although credit policy is viewed as inflexible and contradicting adult learning principles, it has not been changed for 10 years (Xiao, 2006). Despite some discussions about nurse educator-led changes in implementing MCNE (Dai et al., 2004; Huang et al., 2003), no study has examined the emerging leadership of nurse educators in China.

In this study, a nurse educator in MCNE is defined as one who is in charge of MCNE programs. Healthcare organizations are the major setting for most nurses to fulfill their obligations in MCNE (Lu, 2004). However, there is no full-time nurse educator position in healthcare organizations in China so directors or deputy directors of nursing are in charge of MCNE. For the purpose of analysis, they are treated as nurse educators in this article.

### Literature

Flexible, diverse and competence-based learning programs in CNE can prepare the nursing workforce to cope better with challenges arising from a rapidly changing healthcare environment (Nursing and Midwifery Council, 2002; Whittaker et al., 2000). However, nurse educators in China have great difficulty in developing such programs because of the constraints imposed by the credit requirements in MCNE policy (Xiao, 2006). Credit requirements in China are into two categories: Type 1 and Type 2 (see Table 1). Type 1 is in the higher rank of the two types of credit and cannot be replaced by Type 2 credits. RNs must meet 3–10 Type 1 and 15–20 Type 2 credits annually (Chinese Ministry of Health, 2000) which involves approximately 90–160 study hours.

Chinese literature has indicated that most RNs cannot meet the credit requirements. Because Type 1 credits require fees for registration, transport and study leave, only nursing administrators and a very small numbers of RNs take these programs (Cheng et al., 2003). Most RNs, in fact, have never attended outside CNE programs and the main way for them to obtain credits is through on-site programs which focus mainly on basic nursing skills in mass lectures, repeated year after year (Lu, 2004). Nurse educators respond to the constraints of credit requirements differently. Some have developed flexible on-site programs in which independent study, ward-based study, and group learning are conducted in order to increase the RNs’ learning opportunities (Huang et al., 2003). Others however, complying with inflexible credit requirements driven by MCNE policy and their more rigid interpretation of MCNE policy, are more likely to provide repeated lectures or irrelevant but convenient programs for RNs (Chen, 2005; Han, 2004).

In the Chinese context as part of the recent economic reforms, there is a rapidly changing situation where the health care system is being transformed from a centralized system underpinned by a command economy to a decentralized system based on a socialist market economy (Wang, 2001). Healthcare organizations have been devolved to manage their own finance, personnel and services in a competitive healthcare market. Huge deficiencies in RNs’ competencies have been identified and are viewed as barriers for further reform (Chen, 2005; Cheng et al., 2003). All of these external change forces have significant implications for nurse educators leading MCNE in China.

In the literature of educational leadership and continuing professional development (CPD) which includes the category of MCNE, it is argued that a rapidly changing environment demands transformational leaders (Sugrue, 2004; Hallinger and Heck, 2002). The attributes of a transformational leader are described as developing and sharing a vision with their fellow members, including them in decision making on program development and empowering them for change by building capacity for learning (Drago-Severson, 2004; Grundy and Robison, 2004). Such approaches can cultivate a learning community that engages everyone in lifelong learning (Grundy and Robison, 2004). By contrast, transactional leaders who take a managerial approach to problem solving in CPD contribute to policy-driven practice which may undermine educational purposes (Drago-Severson, 2004; Day and Sache, 2004).

There is a strong argument that educational leadership is grounded on expert knowledge in

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**Table 1** Type 1 and Type 2 credits in MCNE in China

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<thead>
<tr>
<th>Learning activities</th>
<th>Type 1</th>
<th>Type 2</th>
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<tbody>
<tr>
<td>National level programs</td>
<td>3 h = 1 Type 1</td>
<td></td>
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<tr>
<td>Provincial level programs</td>
<td>6 h = 1 Type 1</td>
<td></td>
</tr>
<tr>
<td>Organizational level programs</td>
<td>1–2 h = 0.5 Type 2</td>
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education practice and leaders in CPD should be educationalists, rather than technicians (Drago-Severson, 2004; Brookfield, 1988). An educationalist has developed an educational philosophy underpinned by contemporary educational theories. The technician, however, lacks educational beliefs, but follows orders and rules without critique. An educationalist commits to CPD by meeting learners’ needs, facilitating reflective practice and developing level of expertise (Grundy and Robison, 2004; Brookfield, 1988). In the exploration of knowledge and in the information age, expert practice in CPD is built on the use of evidence-based practice, collegial support, networks within discipline and crossing disciplines (Day and Sache, 2004; Grundy and Robison, 2004).

In the Chinese context, there has been almost no additional educational preparation for nurse educators in MCNE. A survey (Xi et al., 2001) found that secondary nursing education was the highest qualification gained by 61% of the 144 CE program participants, who were nursing administrators with responsibility for CNE in one hundred health care organizations. Lack of higher educational background may contribute to a technical approach in implementing MCNE in China. The profile of nurse educators may change in the near future with increased numbers of enrolments of RNs in higher education programs in China (Jiang, 2003), the leadership in MCNE, however, may not be improved if little attention has paid to additional preparation of the educators.

Despite evidence of different approaches to the implementation of MCNE, no research has explored leadership in implementing MCNE in China. In this study, five nurse educators’ leadership behaviors were examined by analyzing their responses to healthcare reform in the implementation of MCNE in China. The following two research questions guided this study:

- What are nurse educators’ beliefs about their responsibilities in implementing MCNE?
- What are nurse educators’ perceived enablers and barriers in implementing MCNE?

### Methods

The purpose of this study is to enrich understanding of different leadership approaches in implementing MCNE by analyzing nurse educators’ experience, rather than exploring cause-effect relationship in leadership development. Therefore, an interpretive approach underpinned by Gadamer (1989) philosophic hermeneutics was chosen to address this research purpose. Gadamer explains that it is impossible for the interpreter to bracket her own beliefs or prejudice when she is involved in interpreting a human action (Gadamer, 1989). On the contrary, socio-historically inherited prejudice derived from one’s culture “is regularly greeted in current thought’’ and influences one’s judgments (Crotty, 1998, p. 103). Understanding is viewed as “historically effective consciousness’’ (Gadamer, 1989, p. 361) and the criterion for judging the truth in this approach is “the harmony of all the details with the whole’’ (Gadamer, 1989, p. 291). This

<table>
<thead>
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<th>Table 2</th>
<th>The profile of five nurse educators</th>
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<tr>
<td>Pseudonyms of participants</td>
<td>Education preparations</td>
</tr>
<tr>
<td>Liufang</td>
<td>Bachelor degree with overseas study experience</td>
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<tr>
<td>Baijie</td>
<td>Master degree with overseas study experience</td>
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<tr>
<td>Chenhong</td>
<td>Bachelor degree</td>
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<tr>
<td>Zhangying</td>
<td>Bachelor degree</td>
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<tr>
<td>Wuhui</td>
<td>Diploma</td>
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methodology, therefore, allowed me to bring any prejudice from my experience as a nurse educator in implementing MCNE in China into the hermeneutic circle of understanding.

This study was approved by the Ethics Committee of the university where I studied, and the Bureau of Public Health in a province of China where the data were collected. Free, informed consent was obtained before each interview. In order to remain confidentiality for participants, pseudonyms were used in this study. Five nurse educators (see their profile in Table 2), with a minimum of two years experience in charge of MCNE in five tertiary hospitals (the highest level of health care organizations) in a province of China, were purposely chosen.

An interview schedule generated from the research questions guided in-depth dialogues with individual participants. Interpreted meaning, developed through understanding-based hermeneutic circles, integrated my participants’ stories with my reflections, the phenomena in China and other parts of the world. Rigor was achieved through the use of the participants’ words to support the themes by which their horizons (an understanding of meaning in an area of inquiry) are represented. In addition, my own horizon is embedded in interpreting dialogues from notes gathered from my field journal and reflection on my previous practice in MCNE.

Results and discussion

Two distinctly different responses to the healthcare reform through nurse educators’ role were identified in this study (see Table 2). As will be shown, Liufang and Baijie were proactive in their approach, while Wuhui was the most reactive. Chenhong and Zhangying indicated the need for changes in the implementation of MCNE. Both Chenhong and Zhangying had made some proactive changes but were more constrained by their organizational environments and educational levels than Liufang or Baijie. Three themes which represent the five nurse educators’ leadership behaviors have been identified: (1) a future-oriented practice versus a policy-driven practice, (2) committing to educational philosophy versus managerialism, and (3) building capacity for learning versus getting the job done.

A vision-oriented practice versus a policy-driven practice

Proactive nurse educators have a vision for MCNE and are motivated to challenge the inflexible credit requirement in MCNE. As two proactive educators stated:

MCNE is a means to prepare nurses to be competent in the ongoing healthcare reform. ... My programs are developed based on my analysis of an annual learning needs survey (Liufang-proactive educator).

I never audit nurses’ credit records as it does not reflect their ability in carrying out patient care. ... My annual appraisal focuses on nurses’ ability required by their role, specialties and position (Baijie-proactive educator).

Visions are personal values for education for the future with which the leader not only sees the current reality, but a possibility of a higher level of achievement and is energized to commit to the values (Hallinger and Heck, 2002). With a vision, the proactive educators transcended the credit constraints and were motivated to investigate learning needs and design competence-based evaluation of learning. Moreover, the vision was built on recognition of multiple stakeholders’ interests in MCNE, rather than complying with an order from a dominant stakeholder. CPD is viewed as a politic intervention used by a government in order to achieve its agenda. There is a danger of generating policy-driven “managerial professionalism” if other stakeholders’ interests are ignored and professional autonomy is suppressed (Day and Sache, 2004, p. 7). Developing and sharing visions with others is a key attribute for the transformational leader in education. This study, however, is unable to explore how the proactive educator catalyzes transformation by sharing vision with members in an organization.

In contrast to a vision-orientated practice, the other three participants, Wuhui, Chenhong and Zhangying were, to varying degrees, concerned with how to follow credit awards policy:

I have to be careful to give nurses correct credit awards. Otherwise, I may be accused as misusing my position when we face the MCNE audit (Wuhui-reactive educator).

I always feel dilemma whether or not giving RNs credits when they actually applied new practice in their wards through self studies (Chenhong-both proactive and reactive educator).

There is no type of credit for informal learning such as consultation and supervision which actually happens everyday for bedside nurses (Zhangying-both proactive and reactive educator).

The findings here reflect reports in the Chinese literature that a tension between MCNE policy and the context of implementing the policy is
inevitable and impacts on the effectiveness of MCNE (Meng and Fan, 2003; Cheng et al., 2003). When a healthcare reform fosters decentralization which emphasizes accountability of healthcare organizations and professionals in China, policy-driven practice will escalate learning paradoxes in MCNE. It appears that there is a need for a greater autonomy for healthcare organizations and nursing profession in MCNE in China. Transformational leadership in MCNE may facilitate such autonomy. By analyzing the proactive educators’ profile, three factors may contribute to vision development for transformational leadership in MCNE: working in the highest level healthcare organizations with better resources, more autonomy and a leadership role in a province, higher educational background with overseas study experiences and a role as national level program developers (see Table 2).

Committing to educational values versus acting towards managerialism

From an analysis of the five participants’ practice in MCNE, this study identifies two belief systems, the first described as an ideal educational belief system, and the second, a traditional system. The ideal belief system is similar to educational philosophy in CPD. The traditional belief, as analyzed below, is underpinned by managerial rules without critique, of convenient approaches in implementing MCNE.

Most on-site programs were developed mainly to meet healthcare organizations’ needs to fulfill regulatory requirements. The proactive nurse educators, however, acknowledged that RNs’ individual learning needs and the need for further development of nursing profession were not met. RNs in organizations with proactive educators were encouraged to study independently:

If they (RNs) publish papers or do nursing research, they can be promoted quickly, regardless of whether they have met credit requirements (Liufang-proactive educator).

(Relating to learning outcomes) We are concerned with nurses’ ability to deliver high quality care to patients, their attitudes towards patients and their ability to learn independently (Baijie-proactive educator).

Publishing papers and doing research were viewed as high level learning with credit exemption. Such recognition of learning has been reported in MCNE in the USA (Lazarus et al., 2002). The policy for promotion developed by the proactive educators indicated that self-directed learning based on individual learning needs and underpinned by learners’ motivation was endorsed. In addition, the proactive educators focused on competence outcomes, rather than credit requirements, by which the limitations of MCNE, described as minimalist learning for re-registration purpose, controlled learning and learning coercion (Grisicti and Jacono, 2006; Carpenito, 1991), may be better resolved. Such commitment to implementing MCNE has created the proactive educator as an educationalist who has knowledge and expertise to integrate policy with complex learning situations.

In contrast, the reactive educator held a traditional educational belief system and worked as a traditional manager in MCNE exhibiting less risk-taking for better outcomes. Their actions were largely guided by credit policy by which the outcomes of learning in MCNE were easily overlooked:

We try to provide as many on-site lectures as we can to support them (nurses) to meet the MCNE. … We never give nurses credit for ward-based learning activities because they are not recognized as part of MCNE (Wuhui-reactive educator).

There are not enough programs for them (RNs) to meet the 25 credits. … They have to attend the self-study examination once or twice a year. … All nurse use the same self-study book each year and attend the same examination organized by the Bureau of Public Health (Zhangying-both proactive and reactive educator).

The negative consequence of following rules without critiquing them by applying educational theories is to reduce learning opportunities for RNs and leads to repetition of learning. Ward-based learning is a kind of workplace learning which generates an ideal situation to engage RNs in experiential learning, reflective learning, problem-based learning and competence-based learning. The diversity of learning styles including formal and informal learning in CPD has been acknowledged (Grundy and Robison, 2004; Nursing and Midwifery Council, 2002). Nurse educators in China, however, face a great challenge to promote whole range of learning activities due to inflexible credit awards and lack of additional educational preparation of nurse educators.

Building capacity for learning versus teacher-centred learning

One of key differences between the proactive educators and the reactive educators is whether they can initiate capacity building for learning in a workplace. Being knowledgeable in educational theories and sharing decisions with RNs in program
development are crucial attributes for capacity building as demonstrated by the proactive educator:

When I develop a program for nursing administrators, I include them in the program development by asking them to prepare topics we plan to discuss. ... During the discussion, I encourage them to analyse their practice in nursing management. ... Participants were able to identify new approaches to improve their practice in this learning style (Baijie-proactive educator).

Strategies used in this program include acknowledging learning interests and motivation from learners’ perspectives as key factors for effective learning, and using experiential-based, reflective-based and inquiry-based learning to enhance learning outcomes. One of the most valuable purposes of CPD is to empower professionals to make a paradigm change in their practice by supporting them to inquire into their own or their peer’s practice, engage in action research and evidence-based practice (Grundy and Robison, 2004). The program described by Baijie did engage a group in inquiry in a supportive peer environment with a high likelihood of changing practice within a healthcare organization.

Lack of knowledge and expertise in educational practice may lead towards teacher-controlled programs that escalate a tension between MCNE policy and individual learning needs:

[At the end of a year], I ask nurses with tertiary education to prepare topics they want to present at the hospital level. I organize a meeting in the Department of Nursing to discuss these topics and choose what we thought are suitable for nurses (Wuhui-reactive educator).

Such ‘top–down’ program development has been reported in Edwards’ (2001) survey that took place in China and is viewed as a barrier for effectiveness in MCNE. The teacher-centred model is similar to a “deficit model” of CPD (Day and Sache, 2004, p. 9) in which programs are prescribed by teachers based on their diagnosis of learners’ knowledge deficits. Risks in using this model include low motivation for learning, unmet individual learning needs and separation between learning and application as reported in MCE literature (Grisicti and Jacono, 2006; Xiao, 2006). In a healthcare reform environment in China, RNs need learning models that empower them to initiate changes to improve their practice. Teacher-centred models, by ignoring RNs’ motivation, real learning need and issues affecting their practice, discourage RNs from engaging in interactions between learning and practice.

Proactive educators believed that holding concurrent posts as a director of nursing and an educator for MCNE had both advantages and disadvantages for capacity building for RNs to learn:

The benefit is to know the entire picture of our nurses and nursing practice very well, and design programs relevant to them. ... The disadvantage of the concurrent post is that I don’t have enough time and energy to do my best to improve the quality of CNE (Liuflang-proactive educator).

The findings in my study about the advantages and disadvantages of holding concurrent posts support the arguments from Glen and Clark (1999) that both academic and clinical competence were demanded of nurse educators in patient-oriented nursing education. In the Chinese situation, due to lack of educational preparation, there is a strong recommendation that nurse educators need academic competencies in educational practice in CPD. My study, revealing the work overload for such nurse educators, also coincides with findings reported by Glen and Clark (1999).

Conclusion

The significance of this research is its findings that proactive educators demonstrate some attributes of transformational leaders. To some extent, proactive nurse educators are able to reconcile learning paradoxes in MCNE at an organizational level by questioning MCNE policy and taking risks to create learning opportunities and build learning capacity for RNs. The reactive nurse educators also demonstrate how an inherent contradiction in MCNE can be escalated by taking a policy-driven approach to practice, without initiation, based on transactional leadership.

The implication arising from this is that transformational leaders at organizational levels, as demonstrated by the proactive educators, have limitations in influencing national MCNE policy. In order to bring about fundamental changes, transformational leadership must be demonstrated at the national level by negotiating through an effective communication channel with policy makers and by sharing their visions with the entire nursing community. Due to small numbers of participants and the use of a qualitative approach, findings from this research have limitations for recommending changes in MCNE, thus suggesting the need for further research in three key areas: (1) how to prepare nurse educators for effective leadership, (2) how to
build collegiality, networks and collaboration for facilitating bottom—up policy development in MCNE, and (3) how to develop workplace learning and learning organization by the means of MCNE.

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