Received: 31 March 2022 | Revised: 17 August 2022 | Accepted: 19 August 2022

DOI: 10.1111/nin.12525

ORIGINAL ARTICLE

Nursing Inquiry WILEY

Beyond transformational leadership in nursing: A qualitative study on rebel nurse leadership-as-practice

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Abstract

Most nurse leadership studies have concentrated on a classical, heroic, and hierarchical view of leadership. However, critical leadership studies have argued the need for more insight into leadership in daily nursing practices. Nurses must align their professional standards and opinions on quality of care with those of other professionals, management, and patients. They want to achieve better outcomes for their patients but also feel disciplined and controlled. To deal with this, nurses challenge the status quo by showing rebel nurse leadership. In this paper, we describe 47 nurses' experiences with rebel nurse leadership from a leadership-as-practice perspective. In eight focus groups, nurses from two hospitals and one long-term care organization shared their experiences of rebel nurse leadership practices. They illustrated the differences between "bad" and "good" rebels. Knowledge, work experience, and patient-driven motivation were considered necessary for "good" rebel leadership. The participants also explained that continuous social influencing is important while exploring and challenging the boundaries set by colleagues and management. Credibility, trust, autonomy, freedom, and preserving relationships determined whether rebel nurses acted visibly or invisibly. Ultimately, this study refines the concept of rebel nurse leadership, gives a better understanding of how this occurs in nursing practice, and give insights into the challenges faced when studying nursing leadership practices.

KEYWORDS

focus groups, leadership, nursing practice, positive deviance, rebels

1 | INTRODUCTION

In the last decade, nurse leadership has been described in many ways (Cope & Murray, 2017; Cummings et al., 2010, 2018; Sfantou et al., 2017), and different styles of leadership have been characterized (Cope & Murray, 2017; Cummings et al., 2018). These leadership styles include transformational and transactional leadership (Bass, 1990, 1999), resonant leadership (Boyatzis & McKee, 2005; Goleman et al., 2002), authentic leadership (Gardner et al., 2005; Walumbwa et al., 2008), dissonant leadership (Goleman et al., 2002), and instrumental leadership (Avolio et al., 1999). Most nursing leadership definitions describe nurse

leadership as the ability to provide a sense of direction with a common goal, influence change, and empower others (Cook, 2001; Cummings et al., 2018; Stanley & Stanley, 2018). Often, nurse leadership is complemented by the word "clinical" to clearly point out whether nurse leadership takes place directly in clinical patient care and/or to improve patient care (Cook, 2001; Stanley & Stanley, 2018). In a systematic review on leadership studies, Cummings (2018) stated that most nursing leadership descriptions are based on the transformational leadership research of Bass (1990, 1999), who emphasized the importance of role-modeling and how charismatic and inspirational leader behaviors develop. In other words, the leader moves the follower, and followers identify with a certain type of leadership (Bass, 1990, 1999). In another review, Cope and Murray (2017) said that "leaders in the healthcare setting are often assumed to mean unit managers, nursing directors, or the facility executives." In contrast, Hutchinson and Jackson (2013) criticized this classical idea of transformational heroic and hierarchical leadership, which is based on position and management roles. Research shows that nurses exhibit leadership even without a designated leadership position (Cardiff et al., 2018; Stanley & Stanley, 2018; van Schothorst-van Roekel et al., 2020).

Besides Hutchinson and Jackson (2013), others have also criticized how nurse leadership has been studied for the last decade (Alvesson, 2019; Carroll et al., 2008; Cunliffe & Eriksen, 2011). For example, Cunliffe and Eriksen (2011) argued that we need to move away from classical "tripod" or "heroic" models of leadership, which seem to colonize the (nurse) leadership literature, towards more relational models and practices of nurse leadership. In addition, Alvesson (2019) argues the need to place leadership in "a *broader context of hierarchical and vertical divisions of work, labor processes and cultural and material pressures from various interest groups*" (p. 38). This view has been amplified by researchers of critical leadership studies, who are urging for less focus on the identities, capabilities, and skill-building of individuals in leadership studies and more emphasis on nurse leadership in daily nursing practices (Carroll et al., 2008; Cunliffe & Eriksen, 2011; Hutchinson & Jackson, 2013). In daily nursing practices, nurses work in interprofessional collaboration with different professionals and their patients (Morley & Cashell, 2017). Hence, leadership should be studied beyond individual capacity (Cope & Murray, 2017; Cummings et al., 2018) and in the context of team efforts and relational collaboration (Jackson & Parry, 2011). In this paper, we show how leadership is exhibited in daily nursing practice in collaboration with other nurses and healthcare professionals.

The relational leadership aspects are mentioned in the review of Cummings et al. (2018) and are classified under the classical leadership perspectives as transformational and authentic leadership.

In a more recent study, Cummings et al. (2021) pointed out that "*Leadership practices are intricately intertwined with the context in which they occur and do not simply depend on the characteristics of individuals*" (p. 10), which suggests research is needed on contexts too. Nurses do not only align their professional standards and opinions of best quality of care with those of other professionals, management, and patients but also align their standards with rules and regulations (Wallenburg et al., 2019) provided by the organization, national legislation, national policies, professional bodies, supervising authorities, and financial restrictions. In an editorial in this journal, Thorne (2021) described that nurses feel *"disciplined and controlled beyond the point of being able to make independent decisions on behalf of their patients to enact the intelligence and expertise that their profession stands for"* (p. 1). Furthermore, managers sometimes have little sympathy or understanding of the nursing perspective (Thorne, 2021). This editorial exposed two distinct worlds: the "life world" of professionals' daily practice and the "system world" of management, rules, and regulations (Stewart et al., 2012; Thorne, 2021).

Reconciling both worlds is not easy because nurses sometimes feel internally contested, for example, if the organizational rules do not align with the patient's needs and wishes. Nurses deal with this by critically reflecting on their working habits, organizational logistics, and quality issues, and sometimes by deviating from the suboptimal status quo (Bevan, 2013; Gary, 2013; Wallenburg et al., 2019). Deviating from the rules of the system world requires leadership in daily practices and the context of work. Several leadership theories and models include deviation of nurses (Boamah et al., 2018; Cummings et al., 2018; Posner, 2016; Stanley & Stanley, 2018). For instance, the Leadership Practices Inventory (LPI) model describes "Challenge the Process" as a core element of leadership (Posner, 2016) whereas the transformational leadership theory highlights the importance of intellectual stimulation where leaders "Challenge the Norm" (Boamah et al., 2018). Although these leadership models mention deviant elements, they mainly focus on the identities, capabilities, and skill-building of individuals. In contrast, deviating nurse leadership practices to improve patient outcomes or ward processes have been described as *"passionate enough to dissent against practices seen as stagnant, ineffective, or even dangerous to those around them"* (Dahling et al., 2017, p. 1167). In their review, De Kok et al. (2021) said "it is unclear what is actually enacted in the practices of positive deviants, healthcare rebels and tempered radicals," a statement that emphasize the need for more empirical studies. However, studying these practices in daily practice is not easy as nurse leadership often occurs "under the radar" (De Kok et al., 2021) or "invisibly" (Allen, 2014).

A suitable perspective for studying these leadership practices is leadership-as-practice (LAP) (Raelin, 2016). Carroll et al. (2008) stipulated and recognized how leadership is connected to a wider socio-cultural context and how leadership emerges through ongoing action and interaction (Raelin et al., 2018; Raelin, 2016; Vuojärvi & Korva, 2020). The LAP perspective is a promising way to bring the leadership practices of nurses, both visible and invisible, into view (Raelin, 2016). In this explorative study, by using the LAP perspective, we aim to respond to the complex, collective, and relational practice of nurses and to provide insights into the practice of nurses who show rebel nurse leadership. Our research questions were: (1) How do nurses experience rebel nurse leadership in their daily practices? and (2) How does rebel nurse leadership emerge in relation to others?

2 | METHODS

2.1 | Design

In this explorative study, we used focus group interviews to collectively narrate nurses' understanding and experiences of rebel nurse leadership. Focus group interviews stimulate in-depth discussion among participants and are recognized as a useful technique for exploring values, beliefs, and systems (Barbour, 2018). We adhered to the Consolidated Criteria for Reporting Qualitative Research checklist (Tong et al., 2007).

2.2 | Study setting and participants

The focus group interviews were part of a larger study design using action research to investigate rebel nurse leadership within three healthcare organizations: two hospitals and one long-term care organization. The healthcare organizations were selected based on convenience but are representative of Dutch healthcare organizations (see Table 1) (Centraal Bureau voor de Statistiek, 2021). Nurses from these three organizations were invited to participate by the nurse advisory board. Inclusion criteria were registered nurses or vocational nurses in training for their bachelor's degree (third- or fourth-year students) and working in direct patient care. Nurses hired from an external employment agency were excluded. The nursing advisory boards sent an invitation email to all eligible nurses explaining the study aims. The first 50 nurses who gave written consent to participate in the study were included. The included participants were evenly spread from the three healthcare organizations. Data on participant demographics are presented in Table 2.

2.3 | Data collection

Eight focus groups comprising 44 nurses and three nursing students were organized by two researchers (EdK and CR) between February 2020 and October 2020. Three nurses were unable to participate at the last minute because of illness or changes in their shift. In total, two focus groups were held in hospital 1, one focus group was held in hospital 2, and five focus groups were held in the long-term care organization. For the focus group, an interview guide was made in advance and included topics on rebel nurse leadership described in the scoping review De Kok et al. (2021) (see Supporting Information: Appendix 1). The focus group interviews were guided by two researchers—one moderator and one facilitator. The role of the moderator (CR) was to conduct the interview, create an open group climate, and stimulate discussion and interaction. The facilitator (EdK) assisted with practical issues and made field notes to maximize the verbal and nonverbal information obtained (Holloway & Galvin, 2017).

Two pilot focus group interviews were held (one in-person in a hospital and one online in the long-term care organization) to test the predesigned interview guide and to optimize collaboration between the researchers. These pilot focus group interviews yielded a lot of useful data, so were included in the analysis (with formal consent from the participants). Every focus group interview started by welcoming the participants, which helped establish rapport

TABLE 1 Demographics of the organizations

Organization	
Hospital 1	This top clinical general hospital has more than 5000 employees spread over eight locations in the middle of the Netherlands. Almost all specialties are represented in the hospital.
	The goal is to provide the best medical and nursing care, together with research and training. Work is based on the mission "Together for quality of life" and the core values are together, involved, innovative, and continuous improvement.
	The management's philosophy is based on "steering together," in which the board, management, and advisory councils are closely linked.
Hospital 2	This general hospital has more than 2700 employees spread over three locations in the middle of the Netherlands. This hospital offers a wide range of outpatient and inpatient care.
	The goal is to provide people-oriented and high-quality care with a human focus and a connection inside and outside the organization. Work is based on the mission "We provide great care, and we will always give you our full, undivided attention" and the core values are concerned, expert, open, and familiar.
	The management's philosophy is based on the idea that "Responsibilities are as close as possible to colleagues in the care process."
Long-term care	This long-term care organization has more than 2500 employees spread over 10 regions in the middle of the Netherlands. This organization offers home care, nursing home care, rehabilitation care, daycare centers, social care, services, welfare work, and private services.
	The goal is to make the lives of residents and clients and the work of its employees as pleasant as possible. Work is based on the mission "Pleasant work, pleasant life care, pleasant living safe, and living together" and the core values are committed and professional.
	The management's philosophy is based on attention to cohesion and interaction.

TABLE 2 Participant demographics

	N	%
Age		
20–29	12	25.5
30–39	15	31.9
40–49	6	12.8
50–59	12	25.5
60–69	2	4.3
Sex		
Female	43	91.5
Male	4	8.5
Base education (highest initial education completed)		
Higher general secondary education	2	4.2
Vocational	20	42.6
Bachelor	25	53.2
Further education		
No further education	34	72.3
Specialization	9	19.2
Otherwise[a]	4	8.5
Years working as a nurse		
<1 year	0	0
1–5 year	14	29.8
6–10 years	4	8.5
>10 years	26	55.3
Nurse Student	3	6.4
Years in the current function		
<1 year	9	19.2
1–5 year	27	57.4
6–10 years	2	4.2
>10 years	9	19.2
Years working in the current organization		
<1 year	8	17.0
1–5 year	15	31.9
6–10 years	5	10.7
>10 years	19	40.4
Setting		
Nursing home	16	34.0
Residential care home	14	29.8
Hospital	17	36.2

[a]Otherwise: Bachelor in Psychology; Education; Management.

(Braun & Clarke, 2006). In the focus group interview, participants discussed rebel nurse leadership practices in their daily work. The moderator stimulated the discussion by asking questions and summarizing the data. The eight focus group interviews lasted approximately 70 min each. Four in-person focus group interviews took place in a private meeting room in the facility, outside of normal working hours. Because of the COVID-19 pandemic, four focus group interviews with participants from the long-term care organization were held online using Microsoft Teams. All focus group interviews were held in Dutch, audiotaped, and transcribed verbatim.

2.4 | Data analysis

To capture nurses' experiences of rebel nurse leadership, a thematic analysis was performed in Dutch as described by Braun and Clarke (2006). ATLAS.ti Scientific Software Development GmbH (2020) and a logbook was kept of all choices made during data analysis.

The thematic analysis consisted of six phases (Braun & Clarke, 2006). First, the researchers (EdK and CR) read and reread the transcriptions of the focus group interviews and listened to the audio recordings to familiarize themselves with the data. Then, each line of the transcripts was read and codes were derived. Field notes were used to interpret the data more carefully. After this initial coding phase, two researchers (EdK and CR) discussed and reconciled any differences in the coding, developed the definitive coding list, and recoded the transcripts based on this finalized list. Next, the codes were merged and clustered into themes and subthemes to organize related codes into meaningful clusters. The themes were named, defined, and described in a document, which was discussed with the whole research team until consensus. Finally, three researchers (EdK, CR, and PLB) examined the data in-depth and critically reflected on the interrelationships to determine whether Thorne (2020) to go beyond thematic coding should be followed. The themes and quotations in the paper were translated into English and checked by a native English editor.

2.5 | Ethical considerations

Before the focus group interviews started, all participants were informed of the study objectives. It was made clear that participation was voluntary and that they could withdraw at any time. All participants gave informed consent to participate. To increase trust in the study, participants were invited to check a summary of the focus group interview, which they received within 2 weeks of participating in the interview. The researchers gave each other feedback (peer review) during all phases of the study.

The Medical Research Ethics Committee of University Medical Center Utrecht approved the study. Data were stored according to Dutch Data Protection Laws.

3 | RESULTS

Four themes emerged from the analysis: (1) talking about rebel nurse leadership, (2) defining good rebel leadership practices, (3) reasons for rebel leadership, and (4) rebels' relations and collaborations.

3.1 | Talking about rebel nurse leadership

Rebel nurse leadership was a new concept for most focus group participants. At first, participants had difficulties describing the concept in relation to their day-to-day nursing practice. For example, one participant said: *"I find this very difficult; what is rebellious?"* (P12, Hospital 2). Research focusing on deviant practices is normative, so we needed a shared understanding of rebel nurse leadership. This understanding was gained by sharing and discussing examples of rebel nurse leadership.

Most participants working in hospitals gave examples of how rebel nurse leadership was exhibited in their daily practice. Many examples were connected to quality improvement on their ward. In contrast, participants working in long-term care found it more challenging to discuss rebel nurse leadership in daily practice and could not give any examples. Long silences were noticed in three of the focus group interviews. This improved slightly after a fictional example of rebel nurse leadership was given. The examples given in these focus groups were related to problems being a coordinating nurse. Defining the difference between leadership in designated and informal leadership roles was particularly hard for them. For example, one participant (22, long-term care organization) talked about how she started a conversation with a healthcare assistant on how to guide a nurse student. She believed that starting this conversation showed leadership because she thought this was a management task.

> *Interviewer: "So, do you now refer to leadership as managing; and you described you feel you take over the manager's seat?" Participant: "Yes, I do." Interviewer: "Is managing similar for you as showing leadership as a coordinating nurse?" Participant: "No, because you do not necessarily have to manage…you can also show leadership as coordinator by collaborating and discussing things among each other [red. other nurses]"* (P22, long-term care organization).

This quote revealed a misunderstanding of what leadership in daily nursing practice is. It was striking that participants highlighted moments when they took on the role or task of a manager or hierarchical leader.

3.2 | Defining "good" rebel leadership practices

In all focus groups, participants described rebel leadership practices as deviating from organizational rules and regulations and professional guidelines. The participants also stressed that deviating from these rules is only acceptable under certain conditions, and distinguished between "good" and "bad" rebel practices.

The participants described nurses who showed "good" rebel leadership as creative and capable of starting experiments: *"…does things slightly differently, with the right intentions, without harming patients or the organization"* (P12, hospital 2). Many examples explained how nurses who showed "good" rebel leadership have a clear fundamental belief and dare to express this to convince their colleagues to do things differently, especially when better quality of care is at stake: *"she is just someone who stands out (…) and goes against the flow… for the benefit of patients"* (P10, hospital 1). Nurses who show "good" rebel leadership substantiate their fundamental belief in professional knowledge and work experience and are hard to convince otherwise according to the participants. They also noted their energy and passion are contagious. They motivate their colleagues to reflect on working habits and to challenge the status quo and improve care. By motivating their colleagues, nurses who show rebel leadership create more critical thinkers who will challenge the status quo with them.

In contrast, participants described complaining and grumbling as examples of "bad" leadership practices. They felt that focusing on self-interests, resisting changing practices, and having negative attitudes show lack of leadership and certainly do not reflect rebel leadership. One participant talked about a new routine in the handover between shifts. She described how some colleagues refused to do the handover at the patient's bedside but continued to do the handover without the patient present. These colleagues did not want practices to change. The participants said that this lack of patient-centeredness does not benefit the quality of care and does not comply with the organizational goals, and they labeled this behavior as "bad" rebel leadership.

Another example of "bad" rebel leadership concerned the reactions of some nurses on social media and national television:

> *Nurses were very negative and expressed their dissatisfaction in the media. When you hear what is being said! (…) I am hurt by nurses who are negative and grumble about what we try to accomplish* (P5, hospital 1).

This "bad" leadership behavior and negative expressions reflected on the whole profession. These nurses try to get national support and want to create followers among fellow nurses too. Therefore, it becomes even more difficult to step up as a nurse leader (especially in multidisciplinary teams) when the profession is seen as rebellious in a negative way because a few colleagues gained (media) attention.

3.3 | Reasons for rebel leadership

Participants agreed that the patient's quality of life was the main motivation to deviate from well-founded rules, regulations, and guidelines. Patient's wishes are more important than the fixed

structures of the ward (such as getting washed in the morning or having breakfast at 8 a.m.). Nurses who show rebel leadership challenged these vested ideas by asking questions and starting discussions on ethics and values. One participant gave an example of a response to initiatives devised by the management that they deemed inappropriate:

> *I try to make it very clear: what is not appropriate or what is not workable. And simultaneously I try to find out what is the goal they [red. management] want to achieve? Next, if I feel it doesn't work, I will explain what will work and try to convince them to do otherwise* (P46, long-term care organization).

Nurses who show rebel leadership were also persistent and were the driving force for change. One participant explained this as:

> *We are trying to stick to our path and not get too distracted by different organizational aims. I think quite a lot is put on our plate, and I also feel free to disregard this or even put it back on the managers' plate. But always in dialogue with the other one (…) I would like to know why and what is the added value* (P23, long-term care organization).

This quote shows that "good" rebel nurse leadership practice does not only concern a negative reaction on an assignment that does not fit how they want to take care of their patients. They always wanted to explain their refusal and present alternatives. Coming up with alternatives, especially alternatives that challenge or change the status quo, without formal consent is rebel leadership, according to our participants. The participants indicated that in this way, nurses who show rebel nurse leadership influence their work practices and justify their belief in giving good quality care to their patients.

When nurses challenge the vested ideas and status quo, they need the necessary social skills to "rock the boat and stay in it" (conform Bevan, 2013). The participants mentioned that nurses who show rebel nurse leadership want to be seen as reliable and professional colleagues. Therefore, their image is carefully created by showing and sharing their knowledge and demonstrating their practical experience. They also set a good example and demonstrate with their actions that the change they want actually works. The adage 'the world changes by your example, not by your opinion' is the starting point for rebel nurse leadership voiced by the participants. One nurse (P17, hospital 2) with over 10 years of work experience talked about how she did not give medication to one of her patients for a physical problem because she knew from experience that other solutions would work better. She discussed this with the physician several times, and when the physician still prescribed the medication without trying her suggestions, she simply did not administer it but went ahead and showed that her alternative approach worked. This kind of rebel nurse leadership shows responsible subversion—they know that they deviate, but can substantiate why they do this. Participants with less nursing experience said in the focus group that they would not dare to rebel in this way because they lack the knowledge and experience to do so with confidence:

> *You have to stand up for your professional values and express your opinion, but that is very difficult. Because you do not have your experience yet, your self-confidence in what you can do is lacking, so I do not feel comfortable to become a real rebel yet […] no, not yet* (P16, hospital 2).

This shows that having knowledge and experience offers space to act as a rebel nurse leader.

3.4 | Rebels' relations and collaborations

Continuous social influences give rebel nurses the drive and courage to overcome obstacles and stir up their organizations. However, they do not want to violate trust in their professionalism, so continuously balance between freedom based on trust and credibility, and the chances of being whistled back. Our participants explained that nurses who show rebel leadership explore the boundaries from which they could deviate. "*After all, nobody wants to be laid off*" (participant 29, long-term care organization). Some participants, mainly from the long-term care organization gave examples of bounded autonomy:

> *So on the one hand, they [team managers] let you determine things, and to take leadership on a particular project. On the other hand, they say: no, back off. We determine what you need to do, and you need to deliver this* (P21, long-term care organization).

However, resistance does not stop nurses from showing rebel nurse leadership. Instead, resistance motivates them to persevere and constantly propagate the value of the envisioned change. One participant (12, hospital 2) explained that, when she gets a "no," *"I just go to the next one. Until I succeed."* Nurses who show rebel nurse leadership build relationships with colleagues to gain credibility, trust, autonomy, and freedom because this helps them to be seen as professionals. Moreover, they actively seek support from other disciplines, wards, or locations. They also discuss their ideas on a different "stage" (e.g., at a quality meeting) or organizational level (e.g., board) and establish connections with others with the same drive and ambition.

> *Then I'm going to make a group of allies, to whom I say, 'can't we just take a look at how we can do that differently?'* (P12, hospital 2).

Nurses need connections for rebel nurse leadership, as described by a participant (12). Several participants mentioned that these

connections support rebel nurses' fundamental beliefs and, as allies, give rebel nurses confidence. In addition, these individuals tell them when they have gone too far and what might damage their trustworthiness.

Participants also talked about how nurses who show rebel nurse leadership switch between acting "above the radar" (visibly) and acting "under the radar" (invisibly) in their organizations. They act "above the radar" if they feel free to perform as a professional. If they are not sure how their actions will turn out, they experiment with their novel ideas invisibly. One participant gave an example of acting "above" or "under" the radar in nursing practice. He said that he had read about new wound materials and ordered these materials without asking his manager for approval. He explained how he weighed up the possible benefits for his patients against the risk of being punished for not complying to the rules.

> *…because you know, it's on the edge of what is accepted. (…) and often when you talk about it, they [the team managers] say 'these plasters are very expensive'. Yes, that's right, they are very expensive, but if you only use them once a week, overall the costs will decrease… (…) And often the team managers tell you upfront no. But if you just do it and if it turns out that it works better, then the team managers afterwards say 'yes, we trust you in it'* (P29, long-term care organization).

Participants emphasized that nurses who show rebel nurse leadership will never choose to do everything 'under the radar' because their invisible actions would damage their relationship of trust.

> *Because if you start doing things in secret, it can also backfire. (…) What are the risks of my choices? What are the limits? And will I still have support among colleagues after that?* (P29, long-term care organization).

By consciously choosing when to act "under" and "above" the radar, nurses who show rebel nurse leadership remain reliable and maintain the support of their colleagues. They do not want to risk being put aside and prevented from pursuing their fundamental belief. These nurses also find it vital that their colleagues participate of their own accord. Therefore, as the participants explained, nurses who show rebel nurse leadership do not go to extremes to make others agree with their beliefs. They do everything they can to be seen as a professional who only wants to improve care.

4 | DISCUSSION

In this study, we asked nurses who were not in designated leadership positions, about their experiences with rebel leadership in daily nursing practice using a Leadership-As-Practice (LAP) perspective (Raelin, 2016; Raelin et al., 2018). By studying nurses' leadership in mundane processes instead of formalized leadership (i.e., management positions), we moved beyond previous studies on nursing leadership that focused on the capabilities and competencies of individuals with a charismatic leadership style (Hutchinson & Jackson, 2013). We also provided more in-depth insights than clinical leadership studies have into deviating practices.

All participants recognized rebel nurse leadership in their daily processes, although the concept/name was new for most participants. The participants found a shared understanding of rebel nurse leadership in the focus groups promoted by the LAP perspective (Raelin, 2016; Raelin et al., 2018) and during their discussions about examples of rebel leadership in daily nursing processes. Our analysis shows rebel nurse leadership practices are embedded in specific situations and circumstances, and are grounded in a normative assessment on "good" and "bad" rebel behavior. The participants substantiated that deviating from rules and regulations was (not) appropriate, especially with regard to their motivation and intentions to deviate and how they deviated. In agreement with our findings, other studies have confirmed this need to clarify good and bad rebel practices; Kelly and Medina (2014) argued that "rebel" is a normative term in itself.

Our participants' opinions and definitions on rebel nurse leadership were consistent with those described in previous studies on positive deviance (Gary, 2013) and rebel nurse leadership in healthcare (Bevan, 2013; Wallenburg et al., 2019). Our findings are also similar to those described in the scoping review of de Kok et al. (2021), who stated that rebel nurses show unconventional nonconformist behavior that varies or differs from norms, rules, codes of conduct, practices or strategies to provide better outcomes for patients and organisations. Our participants complemented these findings by providing reasons for rebel leadership in daily nursing practice. Our findings show that nurses' intrinsic motivation to provide good care gives them the courage to challenge fixed structures and vested ideas by experimenting how things can be changed or by proposing new ideas. Previous studies have described deviating nurses as innovative, creative, and adaptable (Gary, 2013), and have shown that they come up with elegant and efficient solutions to complex problems (Bristol et al., 2018). Our study adds more detail on how aware rebel nurse leaders are of the need for continuous social influencing to change things. They are conscious of the professional boundaries of their colleagues and/or management and make balanced choices on whether to challenge these boundaries or not. Furthermore, they look for support and encouragement from likeminded critical thinkers within and beyond their organization to integrate their ideas into new practices. These collaborations and alliances help them to realize change, and if nobody agrees with their opinion then they stop pushing too hard, which stops them getting kicked out. Early work of Bevan & Fairman on health and care radicals (Nesta, 2014) (they later changed the name "radicals" to "change agents" to avoid negative connotations [NHS Horizons, 2022]) mentioned that there are *"hyperconnectors, building relationships with other change agents and innovators, utilizing open innovation principles to make social connections, pulling knowledge into the organization,*

making sense of it and sharing it to speed up change" (Bevan & Fairman, 2017, p. 25). In our study, we also learned how the strong ability of rebel nurse leaders to reflect on mundane practices, their responsible subversion, their fundamental beliefs, and their profound evidence-based knowledge help to change things for the better. Also, their extensive experience supports deviation and stretches boundaries when needed.

We also found that experimenting within their own practices is key for rebel leadership in nursing. By showing how things can change in practice, nurses can substantiate their opinion. Rebel nurse leadership is not always "above the radar" and therefore visible to colleagues and management. Our participants explained that having the space to deviate and experiment helps them to discover whether their ideas can improve patient care. Wallenburg et al. (2019) showed that deviating "under the radar" allows nurses to test out their ideas, without being whistled back by their colleagues and management. Our study shows trust, autonomy, and credibility are important to nurses acting "under the radar." Acting "above" or "under" the radar is a constant balancing act between challenging the status quo to improve care and simultaneously maintaining the trust in their professionalism and profession. Van Schothorst-van Roekel et al. (2020) made similar observations in their study on experimenting with new nursing roles in clinical practice. We add to their findings that nurses prefer to act "above the radar" to remain reliable and professional. In addition, when nurses decide to act "under the radar," they constantly consider if their invisible actions are ethical and can be justified, and constantly think about when they should reveal their invisible actions. This shows that within good rebel nurse leadership practices nurses do not want to act alone and be hazardous for their organization. This portrays a more positive image of rebel nurse leadership in practice. This should give healthcare organizations and professionals food for thought and should stimulate conversations with nurses about rebel nurse leadership in their own organizations.

The LAP perspective allowed us, to approach nursing leadership as more relational models of leadership (Carroll et al., 2008; Cunliffe & Eriksen, 2011; Hutchinson & Jackson, 2013). While the LAP perspective provided valuable new insights, it also presented challenges.

The first challenge was focusing on the social structures and interactions of deviating practices. In line with the findings of Schweiger et al. (2020), our participants struggled to abandon the individual "heroic" image when talking about rebel nurse leadership at the start of the focus group interviews. This may support the hypothesis that competency thinking is dominant in nurse leadership (Carroll et al., 2008; Kennedy et al., 2013) and that programs to develop these competences (Boamah et al., 2018; Cummings et al., 2021; Posner, 2016), which are mainly based on transformational leadership survey data (Hutchinson & Jackson, 2013), prevent us from observing practices. Moreover, nurses are seldom exposed to the perspectives of complex, collective, and relational leadership (Kennedy et al., 2013; Uhl-Bien et al., 2020). Therefore, the participants were more encouraged to give examples of rebel nurse leadership practices rather than individual identities and capabilities.

Another challenge of the LAP perspective is that it is relatively new and is mainly described as a theory (Carroll et al., 2008; Raelin, 2016, 2019; Raelin et al., 2018) rather than an accepted method for studying nurse leadership (Vuojärvi & Korva, 2020). Only a few examples exist where the LAP perspective was used to collect and analyze data. New approaches incorporating the LAP perspective into our study were carefully selected and used to collect data. This helped us to discover new insights into rebel nurse leadership practices that we could not have obtained using classical approaches. Therefore, this study contributes to the practical implementation of the LAP perspective to focus on relational leadership practices.

4.1 | Limitations and future research

This study has a few limitations that warrant consideration. First, rebel nurse leadership sometimes takes place invisibly "under the radar," so our participants may not have noticed all cases of rebel leadership in their daily nursing practice. This limitation could be addressed in future studies by shadowing nurses to closely observe their leadership practices (McDonald, 2005). This would help to fully understand the interactions, collaborations, and contexts surrounding rebel leadership (Husebø & Olsen, 2019; Lalleman et al., 2017). Shadowing would also overcome the challenges that hospital and long-term care nurses have describing rebel nurse leadership practices. Future research should observe rebel nurse leadership practices and further explore these practices in both the hospital and long-term care setting. Future research could also show how rebel nurse leadership influences care outcomes (Baxter et al., 2019).

Second, rebel nurse leadership practices might be influenced by social gender norms, and even by different cultural values. As shown above, the word "rebel" is a normative term and could imply that nurses are behaving badly rather than as expected to promote quality of care for patients. More empirical research can be done on the deviant behavior of nurses, especially in daily practice in different countries. This will give more insight on the norms and values connected to the profession. Third, because of the COVID-19 pandemic, we had to conduct some focus group interviews online instead of in person. This may have influenced the interaction between participants when responding to statements, asking questions, and entering into discussions. We tried to minimize these effects by allowing a maximum of five participants per meeting so that everyone could be seen on the screen (Barbour, 2018). Fortunately, the structure of the online focus group interviews was consistent, which meant data were collected and analyzed as planned.

Fourth, the generalizability of our findings is limited. Of the 47 participants, 18 worked in a hospital and 29 worked in a long-term care organization, which means we predominantly collected the experiences of long-term care nurses with rebel nurse leadership. Nevertheless, the long-term care organization is divided into separate care services across the middle of the Netherlands, so our results represented the diversity in the nursing profession. However, more research is needed on the differences between diverse sectors using the LAP perspective.

5 | CONCLUSION

This study has provided insights into nurses' experiences with rebel leadership practices. The LAP perspective has given valuable insights into rebel nurse leadership. Interviewing nurses and analyzing their experiences helped to refine the concept of rebel nurse leadership in healthcare organizations. Differences between "bad" and "good" rebel leadership were explained and only nurses who showed "good" rebel leadership were considered leaders by our participants. Good rebel leadership requires evidence-based knowledge, work experience, and motivation to change practices and vested ideas for the patients' benefit. In addition, the ability to continuously influence colleagues and management shows how nurses balance between challenging the status quo to improve care and maintaining trust in their professionalism. Aspects such as credibility, trust, autonomy, freedom, and preserving relationships let rebel nurses decide to act "above" (visible) or "under" (invisible) the radar. Nurses showing rebel nurse leadership are aware that collaborations are needed to improve their practices. Their responsible subversion makes them act to change their practices and shows that challenging the status quo improves patient care. By constantly exploring and stretching the boundaries of their colleagues and management, nurses could have a positive impact on their work environment and patient outcomes. This study helps nurses to recognize and acknowledge rebel nurse leadership practices more, stimulates nurses to show this rebel nurse leadership, helps organizations to understand the intentions of rebel nurse leadership, and gives insights into the mechanisms of rebel nurse leadership. Nurses do not want to be disloyal to their organizations, but always want to give the best care to their patients.

AUTHOR CONTRIBUTIONS

Eline de Kok, Corijna Reede, and Pieterbas Lalleman designed the study. Eline de Kok and Corijna Reede performed the explorative study, including focus group interviews. Eline de Kok, Corijna Reede, and Pieterbas Lalleman analyzed and interpreted the data. Eline de Kok, Anne M. Weggelaar, and Pieterbas Lalleman prepared the manuscript. Corijna Reede and Lisette Schoonhoven commented on the manuscript. All authors approved the final version for submission.

ACKNOWLEDGMENTS

We would like to thank all the participants for sharing their experiences about rebel nurse leadership in this study.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available because of privacy or ethical restrictions.

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How to cite this article: de Kok, E., Weggelaar, A. M., Reede, C., Schoonhoven, L., & Lalleman, P. (2022). Beyond transformational leadership in nursing: A qualitative study on rebel nurse leadership-as-practice. *Nursing Inquiry*, e12525. https://doi.org/10.1111/nin.12525