Assessing leadership in nurse practitioner candidates

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ABSTRACT

Objective
The aim of this study was to explore the concept of leadership as it applies to nurse practitioners (NPs) and examine the issues around assessing NP candidates in Australia for leadership qualities.

Setting
Currently in Australia, registration as a nurse, midwife, enrolled nurse or nurse practitioner is conducted at the state or territory rather than the national level. Nurse practitioner is a protected title in Australia. To practice as a nurse practitioner in Australia, candidates must be endorsed or authorised by the nurse registering authority in the relevant state or territory of Australia. The NP candidate can be based in both hospital and community settings, caring for both inpatients and outpatients, over a range of specialty areas. The context of this paper is Victoria, Australia. Currently there is no national process for the registration of NPs. Each Australian state or territory determines its own requirements.

Subjects
Nurse practitioner candidates in Victoria, Australia.

Primary argument
Clinical leadership is difficult to define and assessment of NP candidates for leadership qualities can be subjective and inconsistent. Leadership is often confused with management and those who are seen by their colleagues as leaders are not necessarily in senior positions. NP candidates applying for endorsement or authorisation to practice as a nurse practitioner are assessed for competency in leadership by the nurse registering authorities with no clear defining criteria. Many of the leadership indicators may fall under a different Standard of Competency for NPs (ANMC 2006).

Conclusions
Those who are seen as leaders do not necessarily fulfill consistent and predictable criteria. Many NP candidates will not have achieved clinical leadership as outlined in the ANMC standards for Nurse Practitioners (2006). Definition of leadership has been notoriously difficult across nursing and other disciplines. The concept of transformational leadership appears to fit the NP model appropriately, although measurement of transformational leadership is as equally problematic as the traditional view of leadership. Until an acceptable definition of clinical leadership for an NP is developed, assessing NP candidates for this quality should be creative and flexible, and recognition should be given that leadership qualities may be in developmental stage.

INTRODUCTION

The evolution of NPs in Victoria, Australia, has been an arduous process. The first Victorian NPs were endorsed by the nurse registering authority in 2004. Each state and territory in Australia has different requirements for the NP candidate to fulfill although nationally consistent approaches to educational requirements and endorsement for NPs are in progress (N3ET 2006). The role of NPs has been opposed by certain groups such as the Australian Medical Association (AMA 2005) which has further complicated the progress of this emerging nursing role. All NP roles are evaluated in the context of their specialty and location (metropolitan, rural or remote; hospital or community) using the Australian Nursing and Midwifery Council *Competency Standards for Nurse Practitioners* (ANMC 2006).

The measurement of NP candidates against some of the competency standards is challenging. One of these aspects, which is arguably the most difficult to define, is leadership. This paper seeks to highlight the difficulties in measuring leadership in NP candidates and seeks to clarify what leadership could mean for the NP. It also proposes creative means of assessing NP candidates for leadership qualities in the absence of clear guidelines.

COMPETENCY STANDARDS FOR NURSE PRACTITIONERS

In order to become endorsed as a NP in Victoria, Australia, there are three generic standards a NP candidate is required to meet.

Prior to interview, the NP submits their curriculum vitae and professional portfolio for assessment. Interviews are conducted by assessment panels consisting of a clinical pharmacologist, a medical specialist, relevant senior nursing personnel and a representative from the nurse regulatory authority.

Following successful interview(s), referees are checked, usually by detailed written forms as well as verbal communication.

By using the ANMC Competency Standards (ANMC 2006) as a measure of NP competence, there is an implication that the standards are accurately and readily measurable. These standards are:

Standard 1: Dynamic practice that incorporates application of high level knowledge and skills in extended practice across stable, unpredictable and complex situations.

Standard 1 is measurable both by the seniority of the position of employment the NP candidate holds and the level of nursing practice achieved. The level of practice includes any extensions of nursing practice beyond the traditional skills level and the complexity of skills the NP candidate uses in practice. The NP candidate may have evidence of further study or experience to gain these skills. The knowledge base, research and learning evidence, and written references given by senior medical and nursing staff working with the NP candidate are also explored. A series of interviews is often conducted, where a NP candidate discusses practice and presents case studies which are thoroughly explored with the NP candidate and the interviewing panel.

Standard 2: Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability.

The NP candidate is required to understand and demonstrate scope and boundaries of practice and works collaboratively with and autonomously within a team of health care professionals. Organisational support needs to be documented and accountability pathways defined. Professional collaborations and relevant service that fits within an organisation as well as having relevance to the designated client group needs to be delineated. It should be clear in the application and interview(s) whether a NP candidate has this organisational endorsement and workplace structure to support practice. The NP candidate's model of practice needs to be clearly articulated and a proactive and progressive approach to practice that benefits the client needs to be demonstrated.

Standard 3: Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service.

Standard 3 is measured by the candidate's ability to engage and lead clinical collaboration that benefits their client base and influence at the systems level of health care by engaging in and leading informed critique (ANMC 2006). Carryer et al (2007) support the ANMC stance by proposing that the leadership role is related to clinical practice. This role develops and extends clinical skills in the context of health service delivery. These authors also suggest that NPs inform and guide local and national health policy.

While Standards 1 and 2 have clearly measurable parameters, Standard 3 requires individualised creative arguing of the case. It is contended that this area is the one that is most difficult to measure; each nurse may demonstrate clinical leadership in a different way and in ways that are less well articulated than Standards 1 and 2.

Difficulties Evaluating Standard 3

In some ways the measure of Standard 3, clinical leadership qualities, overlaps with Standard 1, for example, being a senior member of a team. Daly et al (2004) suggests that this leadership is embedded in the concept of clinical experts being involved in the provision of patient care.

Mentoring and supervision are documented. Informed critique and influence at systems of health care level are valued. Brown and Draye (2003) suggest that the emerging of new nursing roles such as those of NPs inevitably result in changes in the health care system. The NP is an integral part of this process.

However Standard 3 is less readily measurable and more open to the interviewing panel's interpretation. The NP candidate can provide evidence to demonstrate leadership, but this will vary significantly with each individual candidate, and the provision of this information is far more open to interpretation by the candidate and the panel than the clearly defined parameters of Standards 1 and 2.

Gardner et al (2006) found the competencies surrounding leadership (Standard 3) to be less robust than those in Standards 1 and 2 and found data on the leadership qualities of NPs to be 'tentative but convincing'. This may be due in part to the relative newness of the NP role at the time of the study, but no such difficulties were found with supporting Standards 1 and 2.

The NPs who were interviewed as part of the Gardner et al study showed a commitment to leadership both in the clinical role and in the health system, although detailing how this was demonstrated in practice was mainly focused on the concept of pioneering the NP position. Gardner et al appeared to indicate that because the NP role is embedded in a strong base of clinical expertise and education and awareness of the articulation between nursing and the health service delivery, NPs are therefore leaders.

NURSE PRACTITIONERS DEMONSTRATING LEADERSHIP

Nurse Practitioner: Leader in the Field

A nurse practitioner candidate in Victoria is required to provide evidence of 'significant leadership in the category' (NBV 2006). The Final Report of the Task Force for Nurse Practitioners (DHS 1999) recommended that the core components of the NP role should include:
- advanced clinical practice,
- education encompassing client education and professional development,
- counselling,
- research and quality improvement, and
- administration and management.

Somehow these core components seem to have been overshadowed as the role of the NP evolves and the current expectations are that NPs are leaders in their field. Leadership is discussed in the DHS (1999) report however it refers to the leadership of the Department of Human Services by providing assistance, funding, advocacy and guidance to the NP candidates.

Much of the literature associates NPs with leadership without really explaining how leadership is defined, with the assumption that the concept is understood. For example, Gibson (2006) infers that nurse leaders are team or unit managers and that leadership equates to ensuring patient care plans are implemented and staff are managed. Although these

aspects may be features of leadership, leadership cannot be restricted to management roles. Milstead and Furlong (2006) propose nursing leadership involves conflict resolution, communication, critical thinking, delegation, and documentation. This demonstrates the traditional view of leadership where leadership is limited to a set of functions or qualities. Kerfoot (2001 p.59) suggests that "leadership can be seen as the practice of small actions that can engage or alienate or nourish or deplete those around us". Colourful and inspiring as this description is, it is not useful in attempting to measure clinical leadership in the NP candidate.

Bryant-Lukosius et al (2004) make the distinction between leadership and 'transformational leadership' suggesting that transformational leadership should characterise the NP's practice. Transformational leaders are said to use ideals, inspiration, intellectual stimulation and individual consideration to influence the behaviours and attitudes of others (Bass and Avolio 2000); moving followers beyond their areas of self interest (McGuire and Kennerly 2006). Being a visionary is said to be a key element of transformational leadership (Daly et al 2004), fostering a sense of direction and common purpose, guiding decision making and creating momentum towards goal. Lack of literature or guidelines detailing specific assessment criteria in this way makes assessing transformational leadership problematic.

Daly et al (2004) suggest that newer leadership theories focus on the processes. In these theories, leadership is seen as a collective process among groups, directed toward a common goal. If leadership is indeed expressed through groups, individual assessment of the NP candidate may be difficult.

There is a diverse understanding of leadership including clinical leadership in the literature. A particular theory or definition has yet to be widely accepted.

COMPONENTS OF LEADERSHIP

It has been proposed that examples of leadership for NPs includes but is not confined to being pioneers (Stanley (2005); change agents (Busen and Jones 1995); mentors (Hayes 2001); and advocates (Daly et al 2004). However even with these examples, practical application and demonstration of these aspects of leadership may be problematic. Not all NPs will be pioneers, change agents and mentors, although most will demonstrate features of advocacy. Each will however, demonstrate varying degrees of leadership in their own distinctive way.

Pioneer

It is often said that NPs are clearly pioneers, forging the way ahead. Brown and Draye (2003) discuss pioneering as establishing, maintaining and building the NP role. They discuss the need for early NPs to advance autonomy to make a difference and break free of traditional nursing roles and limitations. Forging new partnerships and relationships is vital for this process.

Demonstration of involvement as a pioneer or change agent may be possible if the NP candidate has taken a leading role in the process. For a NP candidate to become endorsed there is much background work that is undertaken by both the candidate and others who support and have supported the role in many ways. In the USA where practicing NPs number more than 70,000 (Boyd 2000) compared to Australia which boasts less than 200 (Dunn 2006), some NPs are no longer wishing to regard themselves as pioneers. Kodiath (1995) claims that the age of pioneering is over for NPs in the USA. He argues that NPs now need to develop interdependent team-based practices with the patient as a team member. He cites the need to experience influential relationships between leaders and collaborators intending real change for mutual purposes. The concept of leadership being pioneering, if we are to follow the American example, is most likely a measure that is limited to the development of the NP role and may not be applicable to NPs in the years to come, as NPs become established and accepted in the Australian health care system. Thus in these early stages of the movement of NPs in Australia, the concept of pioneering may be appropriate, but this aspect of leadership may need to be revisited in

years to come as the NP movement becomes more accepted and established.

Role Model

Joyce (2001) suggests that registered nurses (RNs) benefit from the NPs' capacity to promote the nursing profession both developmentally and publicly. NPs are in a position to be able to mentor RNs and assist them with developing practice. Mentoring is seen to have a dual benefit to both the preceptor and the student (Griffith 2004). Not all role modeling is seen as successful however as the benefit can be hindered or facilitated by the NP and preceptor student's demographics and personality, experience of the NP, and the clinical setting (Hayes 2001). Being a role model certainly fits with leadership qualities, both in the traditional sense of leadership and the transformational leadership model.

When assessing NP candidates, the candidates themselves may be asked to convince the panel of their leadership as a role model or mentor. Mentoring could be included by implication in Standard 3, Competency 3.1d (ANMC 2006), through participation in intra and inter-disciplinary peer review. However unless the mentoring is formalised, it is often not the individual who defines whether someone is or is not a role model. NPs may be able to provide evidence of informal mentoring, although measurement may be difficult if the mentoring or role modeling has not been documented.

Another key element of leadership is said to be delegation, or letting go (Daly et al 2004). This is a final but important step of the role modeling process. Letting go involves the role model relinquishing a role or opportunity and supporting the other in the delegated role; allowing the other to extend practice.

It is not clear who is the most appropriate person to determine whether or not a NP is a role model, whether it is the NP, a colleague, or those who are being mentored. Accurate measurement of this quality can therefore be uncertain.

Change Agent

The capacity to be a change agent is not limited to NPs; Skelton-Green et al (2007) suggest that to manage change is integral to leadership. To become a change agent in nursing, a nurse must be able to deal with resistance, as the prospect of change inevitably invokes resistance. Dealing with conflict resolution is also paramount (Strunk 1995), as resistance and hostility is a common experience of change agents (Brown and Draye 2003).

Many NPs are remodeling advanced nursing practice and policy. As their roles evolve, they are often at the forefront of nursing, defining practice, advocating for patient rights, and implementing evidence based practice in their workplace through participation in and application of research. Buonocore (2004) suggests that to be a change agent is leadership in action, in the context of leading the way to change practice.

Change of practice and policy usually involves a number of people over a period of time and often includes managing resistance. Documentation of individual involvement in the process may be difficult to demonstrate. Many change agents work collaboratively, slowly, over time, establishing professional networks and initiating and implementing change. There may be others who take accolades for the work that has been performed by many others over time, sometimes due to their senior position at the time the change or progression has taken place.

Influencing health care policy and practice are certainly examples of being a change agent (ANMC National Competency Standards for the Nurse Practitioner, Standard 3, Competency 3.2 Engages in and leads informed critique and influence at the systems level of health care). This would be one indicator that is measurable and clearly directly related to leadership. An example of this would be various individuals, groups and organisations lobbying the government about a particular issue to bring about legislative change. Changes to several Acts were required before NPs were able to practice. These included The Health Legislation (Amendment) Act (2003), The Nurses Amendment Act (2000) and The Nurses Act (1993). Amendments were also required for the Drugs, Poisons and Controlled

Substances Act (1981) in order for nurses to be able to prescribe medications from a limited formulary. Nurses who were part of forums, advisory groups, committees and taskforces advising and making recommendations to the Department of Health could be regarded as change agents, preparing the ground for NPs to practice in Victoria.

Other examples of change agents could be the NP who works collaboratively to produce an evidence-based clinical practice guideline that changes practice, or the NP who sees inequity in the health care of a client group and applies for funding to set up a more appropriate practice.

Advocate

In close alignment with being a change agent is the notion of advocacy. Many NPs are advocates, advocates for their patients, for health issues and for the progression of nursing. Advocacy is said to be a combination of individual and social actions with the end goal of political and community support for a particular health program or goal (Daly et al 2004). NPs need to be aware of the social and political contexts in which they work, as well as maintaining effective communication with colleagues. Establishing networks and effective channels of communication with relevant stakeholders are also important for advocacy.

The Australian Nurse Practitioner Association is associated with the International Council of Nurses (ICN). This forms a part of the World Health Professional Alliance, which advocates for sustainable and accessible health care for all, health and human rights globally, as well as gender issues and equal opportunity. Active membership and support of this group could also be seen as evidence of leadership and as change agents for equitable global health care.

Advocacy is not a unique feature of clinical leadership for NPs. To be an advocate is important in all levels and fields of nursing. It is however an aspect of clinical nursing leadership that would be relevant to NP candidates.

IS LEADERSHIP LEARNED OR INNATE?

It is interesting to consider whether a nurse can actually learn leadership or whether leadership qualities are innate. When people are seen as leaders it is sometimes unclear whether they are seen as leaders in terms of function or intrinsic quality. It is also unclear who it is that determines nurses to be leaders: managers, peers, patients or those external to the workplace. With nursing, it is generally management at a higher level that designates; appoints leaders; team leaders; unit or ward leaders. However management is better suited to determine managers rather than leaders. And the two do not necessarily go hand in hand. A nurse is able to be a nursing leader without holding a senior position. Conversely, a nurse is able to work at a senior level without being a leader. There is often an understanding that leadership qualities develop, in a similar way to gaining wisdom with age. However some nurses are never seen as leaders as they age. The argument for seniority in position equating with leadership, which may come with experience or promotion, is a difficult concept to be confidently applied.

Multiple courses abound which claim to make people better leaders and this perhaps reflects the possibility that there are many people in leadership who need to acquire strategies and skills to assist them to lead. However evidence of completion of one of these courses is not necessarily evidence that a NP candidate is a leader.

A similar argument can be proposed for the requirement for NPs to have master's level educational preparation. These courses are designed to prepare a nurse for practice at NP level and, according to Gardner et al (2006) the students of these courses felt strongly that a clinical component was important to support theory. Although the students reported the course gave good preparation for practice as an NP, it is unclear whether they felt prepared for a leadership role. Most NP courses in Australia are at a master's level and some of these courses contain study

areas pertaining to clinical leadership (Gardner et al 2006). It is not clear how this leadership component is assessed, however it is likely that study of areas such as legal and political frameworks and managing change, as well as advanced nursing education would presumably prepare the nurse for clinical leadership. The inconsistency of the NP courses across Australia noted in this paper further highlights the difficulty NP candidates would face in preparing to argue their own case for being a clinical leader by virtue of having completed a master's degree in preparation for their NP role.

WHAT IS LEADERSHIP?

There is a difference between leadership and management. Management implies directing, controlling and/or supervising. NPs are expected to be senior members of a health care team (ANMC Standard 3, Competency 3.1 *Engages in and leads clinical collaboration that optimise outcomes for patients/clients/communities*). Stanley (2006) sought to elicit the qualities of clinical nurse leaders. A surprising finding was that the nurses seen to be leaders were not necessarily in senior positions.

NPs may well manage a clinic, but management usually (but not always) refers to power elites that can be distanced from the practical work of an organisation. Although NPs may hold senior positions, their main function lies in advanced clinical practice. As the NP role evolves, it is important to remain mindful of this concept.

Undertaking a course of study does not necessarily determine the suitability of a NP candidate, nor does their workplace position. Being a manager is not a pre-requisite for candidature, although most NPs are expected to be working in senior positions and one of the measures of their leadership is often seen by their position.

Rost (1991) suggests that the large majority of leadership scholars accept definitional permissiveness and ambiguity of the concept of leadership. It is not surprising therefore that clinical leadership in nursing is so difficult to define. He suggests leadership should be defined in the context of the interactive

and dynamic relationship between the leader and the followers.

Leading Whom?
The term leadership implies that the person is leading a person or a group. With many NPs, their role may be working alongside medical or other staff, or they may be a part of a team of NPs working in a particular specialty rather than leading. The concept of authority or election is also often implied, which again may be difficult to apply to NPs.

Leading How?
A distinction needs to be made between those who lead and effective leaders. In history, some visionaries who were leaders used their influence with devastating effects (eg Adolph Hitler). Some in leadership positions closely guard clinical or professional opportunities for themselves, take credit for other's work, or only share opportunities if they themselves are unable to partake. They are generally not seen by their workplace as effective leaders (Stanley 2006). Conversely, those who share opportunities and accolades, and seek to develop the expertise of others regardless of gain for themselves portray themselves as leaders who are not self seeking, and set an example to others of responsible and commendable leadership to which others aspire.

Effective leaders in nursing raise others to higher levels of practice and provide opportunities for skill development. Those leaders recognised as effective act with integrity and use ethical practice that aims to reduce health care barriers for minority or marginalised individuals and groups (Milstead and Furlong 2006).

Clinical leadership defined
The concept of clinical leadership with regard to NPs is sometimes hard to define and difficult to quantify. Interpretation can be seen by either role or qualities or both. Leadership qualities can be both innate and learned. Clinical leadership of the NP is multifaceted and results in change. Change can be at policy level, professional level, or at the patient level. Demonstration of clinical leadership

can include but is not limited to having a recognised advanced clinical nursing role; being knowledgeable; mentoring or facilitating; inspiring or motivating others; maintaining an ethical practice; promoting or developing the nursing profession; or developing new initiatives.

Assessing leadership in a NP candidate according to ANMC Standards

Professional position

It is expected that a NP is a senior member and/or leader of a team (ANMC 2006: Competency 3.1a) and actively participates in influencing health care policy at a local and national level (ANMC 2006: competency 3.2). Seniority is valued, although this may not reflect clinical expertise or whether the candidate is an effective leader.

Influences systems level of health care

Standard 3 of the ANMC Competency Standards for NPs (2006) states that: *clinical leadership that influences and progresses clinical care policy and collaboration throughout all levels of health service.* Policy work and policy development are key indicators. Researcher, clinical teacher, case coordinator and spokesperson are examples of this role.

The importance of influencing policy making and patient advocacy cannot be underestimated, as health care is always on some political agenda and participation in decision making processes enables those who shape policies to be informed. Contributing to the body of knowledge of nursing is also vital. Influencing policy, researching and teaching may benefit the patient. However, many researchers are not considered leaders and many teach without leading. Fulfilling these roles may or may not be examples of leadership, depending on the outcome of the activity and the change effected in the recipients.

Engaging and leading clinical collaboration (ANMC 2006: Standard 3, Competency 3.1)

The indicators listed under this Competency include establishing effective communication strategies; articulating and promoting the NP role; and monitoring one's own practice (3.1 b, c, d). Although

attributes such as collaboration and consultation are demonstrable, these attributes are not limited to NPs. These qualities are important for all nurses and are vital to practice as nurses work collaboratively within an often multidisciplinary team. Requirements for NPs to provide evidence for advanced practice may be formalised in some states or territories of Australia. Although these are important activities they do not directly measure clinical leadership of the NP.

Research and publication

When attempting to measure leadership, a NP candidate's willingness to participate in and initiate research is taken into account. Key application criteria for NP candidates in Victoria includes: *evidence of independent involvement in research activities in relation to their practice, and evidence of significant leadership in the practice area in which they are applying for endorsement* (NBV 2006 p.15).

The Competency Standards for Nurse Practitioners make no mention of publication with regard to leadership, although Standard 1 includes conducting research as an indicator of competency (Competency 1.4). However publications, especially publications in academic journals, are given much credence. Exploring the difference between publishing in academic journals and producing quality patient information literature illuminates the inconsistencies in the way the NP candidate is assessed in this area.

Academic Journals

Publishing in a peer reviewed professional journal can take many months of preparation, writing and revision. Professional development is enhanced and the benefits hopefully filter down to the patient. Other publications include developing patient information literature which can be of direct benefit to the patient.

Developing *quality* evidenced based patient information literature often is in conjunction with of research or review. Although the professional and public scrutiny of patient information literature does not currently compare with publication in academic journals, the pursing of quality evidence

based patient literature can be a practical application of the knowledge gained from clinical research. Despite patient information literature not usually being subject to the same rigour as peer review, it requires dissemination among relevant stakeholders, sometimes including nursing, medical and allied health professionals and consumers. This collaboration and participation in the process surely supports a NP candidate's credentials towards the goal.

Developing patient information literature meets criteria outlined in ANMC (2006) Competency Standards for Nurse Practitioners (see competency 1.2.4; 1.2.7; 1.4.1; 1.4.2; and 2.3.2). In the assessment of NP competence, publications would more likely fit under ANMC Standard 1 than in the assessment of leadership, although citations, practice change, and clinical impact are measurable parameters that could reflect clinical leadership. This exemplifies the creative boundaries for assessing leadership that can be applied to the NP candidate.

Examples of a NP candidate's demonstration of leadership

1. Actively contributes to the body of knowledge in nursing

Demonstration by: presentations at inservices, seminars, workshops and/or conferences; research, scholarly journal publications; contribution to development of evidence based patient information literature; involvement in nursing forums, discussion groups.

2. Professional recognition

Demonstration by: professional or organisational awards or recognition; leadership roles in a professional organisation; grant writing success; invitations to guest lecture; case co-ordinator; consultation activities.

3. Role model or mentor

Demonstration by: unsolicited comments or feedback from patients; peer review or evaluation; 360 degree evaluation from supervisor/peer/subordinates; evaluation from student following formal mentoring, clinical teacher, higher degree student supervision.

4. Change agent

Demonstrated by: membership of professional local or international organisations, forums, advisory groups, taskforces, committees; being a recognised spokesperson; publicity opportunities, multidisciplinary collaboration across academic and or professional organisations; evidence of involvement in development or redirecting of a nursing role; lobbying for legislative change to support nursing initiatives; grant writing success.

CONCLUSION

Clinical leadership is complex and difficult to determine. Clear parameters have yet to be established that conclusively evaluate competency in this area. The performance indicators and competencies in the ANMC National Standards for Nurse Practitioners (2006) that are intended to measure leadership do in fact measure important qualities, however it is not established that these qualities accurately reflect those of leaders.

The NP movement in Australia is relatively young compared with some other nations and leadership is a dynamic and evolving quality that takes on different meanings according to context. Definition of leadership is open to interpretation and there is no generic definition that fits across different contexts. Often those defining leadership do not distinguish between leadership and management. For many NP candidates or beginning NPs, leadership qualities may be in the developmental stage. This needs to be recognised when assessing NP candidates.

As the criteria for leadership is complex when applied to NPs and its definition and practical application is largely unclear, those seeking to assess those qualities should be creative and flexible in their approach. Leadership qualities are worth developing and will assist the further development of the role of the NP. NPs are and will remain under scrutiny from others because of their extended practice and need to continue to provide exceptional clinical care, as well as promote nursing and advocating for nurses and patients at all levels of the health care service. Additionally, the degree of leadership skills and

attributes demonstrated by different NP candidates may vary considerably.

Until leadership is clarified with respect to NP's roles, assessment for NP candidates in this area should allow for discretion by both the NP candidate and the assessment process.

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