



Fostering nursing leadership in times of political flux

Professor Mary Chiarella
Centre for Health Services Management, UTS
Nursing and Midwifery Office, NSW Health



Today's discussion

- Going to ask (and attempt to answer) the questions we prefer not to hear but which any of us in leadership positions have probably been asked
- Going to explore the intersection between nursing career paths, politics and research evidence



Nursing leadership: the questions we prefer not to hear

- What can a perspective from nursing bring to this issue?
- Couldn't that perspective be supplied in some other way?
- They don't have to be nurses to do that, do they?
- What is it that makes that nursing work?



Issues that those questions evoke for me

- What ought nursing leadership to look like?
- How should nursing leaders function?
- Where should nursing leaders be situated?
- What frameworks and conceptual models might assist us to understand nursing leadership in times of political flux ?



Situating nursing leadership in times of political flux

- In NSW at present “Workforce” is the buzz word and each AHS has a Director of Workforce, which is a multidisciplinary operational position
- In addition, there is an Area Director of Nursing who has “professional” responsibility for nursing
- Senior hospital nursing positions are only being maintained because of union pressure and sometimes across 2 sites
- Many of them are not operational roles, nor do they have line management responsibility for nursing
- NSW has undertaken a couple of overseas recruitment campaigns to fill our clinical nursing vacancies reasonably successfully, although obviously not all of these will be permanent



Situating nursing leadership in the politics of health

- Currently there is a strong push from the opposition (and some sectors of the public) to move nurse education back to hospital based training as a means to address the nursing shortage
- Some senior nurses have assisted the opposition to develop this policy
- There is also a call from the aged care sector for unregulated health care workers who are medication endorsed to take the place of enrolled nurses
- There is also a shortage of medical practitioners and NPs have gained purchase as a result of this shortage
- In addition, patient flow and access to acute care beds is a major initiative of government, with \$78M being allocated to the Clinical Systems Redesign Project

Political Imperatives	The mantra of multi-disciplinarity	Shortage of doctors	Focus on throughput & access	Focus on throughput & access	Shortage of RNs	Nursing shortage, cheaper, immediately in the workforce	Nursing shortage, cheaper, immediately in the workforce	The mantra of multi-disciplinarity Nursing shortage, cheaper, immediately in the Workforce, regulatory constraints
Categories of nurses	Senior nursing management	NP	NUM	Non-award Positions eg CIN, PN	RN	EN	AIN	Generic Health worker (PCA, Cert IV aged care)
Evidence to support arguments re staffing and positions	Taunton et al, (1997) Magnet studies	Sackett (1974) Mundinger (2000) SRs	NSW Health experience in CSRP	NSW Health ideas implemented through CSRP	Aiken's work to demonstrate importance of baccalaureate staffing	Aiken's work assisted with managing ratios to some extent	Some evidence to suggest valuable step up to nursing careers in future	Private sector impetus NHS UK (no ENs there)



What does all this mean for nursing politically?

- A lack of a formal nursing management structure runs the risk of depleting senior nursing leadership
- In turn this could mean a lack of advocacy for nursing views and issues
- Nursing unions are unhappy about the lack of senior nursing leadership through the restructures: this is conveyed through their journals to clinical nurses
- Turnover of itinerant workers can create instability of the workforce and reduce the potential for developing senior clinical nursing leadership in the absence of senior nursing management leadership
- These combined factors can create a dispirited and/or docile clinical workforce and a lack of clinical nursing leadership



Does it matter?

- Returning to those original questions:
- What can a perspective from nursing bring to health?
- Could that perspective be supplied in some other way?
- Would health care delivery be worse if there were no nursing leadership –or indeed no nurses?



What can a perspective from nursing bring to health?

- Currently a strong 24/7 operational perspective (this has implications for nurse education and staff deployment)
- Understanding (because of proximity) of the key issues affecting patients and their families (may be lost if nurses do not deliver front-line care)
- Clear eyed understanding that life is often neither rational nor fair (this is useful for realism)
- Comfort (by and large) with discussing intimate and/or difficult issues (this is useful for challenging behaviours of managers)
- Knowledge that ordinary people are capable of greatness (this helps us not to despair)



Nursing is 2 things...

- The care of the sick and the potentially sick
- The tending of the entire environment in which care happens
- (Diers 2004)



What nursing offers (Pearson, 2000)

There is little doubt that health services will always need a generic worker who is client-focused, possesses multidisciplinary skills, manages the care environment, delivers all but the most highly specialized services to the client, humanizes the system at the point of contact, and acts therapeutically as the experience is lived by the client. This is historically the broad, flexible role ascribed to those titled 'nurse'.



Threats to what nursing offers (Pearson, 2000,cont)

- Increasing cost containment and the scramble for the creation of new occupations within the broad field of health services holds many threats to an occupation such as nursing, which is still plagued with outmoded pretensions in relation to professionalisation and an increasing rigidity regarding role boundaries.”



Could that perspective be supplied in some other way?

- What we have to offer that is unique stems from our prolonged, intimate and regular contact with patients on a 24/7 basis
- Our craft is an amalgam of informed clinical skill and professional compassionate care
- Who else might be able to supply that perspective?
- Possibly unregulated health care workers who are actually practising part of nursing anyway – e.g. Weston Park
- Possibly patients/consumers and carers themselves



Back to the difficult questions: would health care delivery be worse if there were no nursing leadership –or indeed no nurses?

Can nursing leadership exist in the absence of a nursing management structure?

- What is the purpose of nursing leadership?
- How do we perceive nursing leadership ?
- Does nursing offer something different to that which can be offered by unregulated health care workers?



Can nursing leadership exist in the absence of a nursing management structure?

- Potentially yes – medicine has exercised power in health for years, often with little or no medical management structure
- But in order for us to decide this question, we need to be clear about why we want to lead anyway



What do we hope to achieve by “leading”?

- Improved patient care?
- Improved safety and quality in health care?
- An improved health care culture?
- Or...
- Just greater control for nurses?
- Leadership cannot be about “nursing for nursing’s sake, it must be about nursing for the patient’s sake” (Adrian, 2000)



So if “leading” is about improved patient care, is it desirable to restrict it to managers?

- How can clinical nurses speak with a voice of authority?
- Is there a need for health care managers to be nurses?
- Is managing health care nursing work?



How can clinical nurses speak with authority?

- Through using the best available evidence to inform practice
- Through having a strong and resolved value base - PD
- Through demonstrating empirically that skilled nursing care makes a difference to both safety and quality patient outcomes – the gift of nursing research
- Through being sufficiently articulate and confident to feel entitled to have their voices heard -models of care work very helpful in this regard
- Through feeling ownership over an area of practice/inquiry –clinical career paths



Is there a need for health care
managers to be nurses?

AND

is managing health care
nursing work?



Probably the answers are no and yes

- PROBABLY NO because there is evidence to demonstrate that other competent clinicians can be health managers
- HOWEVER, PROBABLY YES BECAUSE
- By and large people who have undertaken nursing education and practice would in this climate have a better understanding of the 24/7 operational hospital environment than those who have not
- Thus a compelling argument becomes that this understanding means nurses are best placed operationally to manage health care, not just nursing (and herein lies the conundrum)



Nursing leadership –apartheid or secession?

- We cannot withdraw into nursing
- If we are competent to manage nursing services, we are competent to manage health services
- If we are experienced, educated, skilled clinicians, we are competent to lead debates about health care, not just nursing care



How do we perceive nursing leadership? What ought nursing leadership to look like?

- “Nursing – born in the church and bred in the army” (Gillespie, 1990)
- Expectation of individual militaristic leadership styles – Chief Nursing “Officer” an example
- Difficulty with this militaristic sense of leadership is that it carries with it an expectation of obedience and loyalty as the primary behavioural states



Problems with militaristic leadership style

- From a clinician's perspective an obligation of obedience will do nothing to foster a sense of entitlement
- From a patient's perspective loyalty is not the same as integrity, and will not necessarily improve patient safety and quality



How should our nursing leadership function?

- We need to look at health, not just nursing
- We need to form real partnerships with the community – the midwives have done well!
- We need to be clinically and operationally focused
- We need to be concerned with bottom-up leadership as well as top-down
- We need to be able to differentiate debate from dissent and disagreement from disunity
- We need to decide how we are going to communicate



Looking at health, not just nursing

- Only nurses are interested in nursing
- Decisions about health are made every day
- Nurses, being the single largest group in health, are impacted on by those decisions
- Therefore we need to be politically active in order to influence them
- Ministers need good advice
- Ministers' diaries are full every day
- Ministers want to be re-elected –they don't want to make mistakes



Being clinically and operationally focused

- Health care is about keeping people well, making people better, and caring for people who can't look after themselves
- Nursing needs to speak with authority on how best to make these things happen
- This requires language –language requires research and data



Bottom up as well as top down leadership

- Governments are concerned by trends, lobby groups, publicity
- There will always be multiple pressures on government funds
- Everyone has a “pet” solution
- A docile group is one you don't have to worry about
- A group that never comes to the party is one you can't bother with
- Individual advice from bureaucrats will only be followed if pressure is applied externally



Bottom up as well as top down leadership

- It is therefore necessary to create a level of strategic tension between lobby groups and government
- The lobby groups need to have key bureaucrats (in our case the CNOs but also other key strategists) in agreement with and appraised of the solutions you believe will make a difference
- Lobby groups need to be coalitions of interested parties, eg nurses and consumers, not single issue groups such as nursing alone (and remember that "circumstance can make strange bedfellows")

Differentiating debate from dissent and disagreement from disunity

- Our military style culture saw disagreement as mutiny and discouraged “insubordination”
- Nurses who challenged the status quo were seen to be subversive
- Consequently nursing has suffered from the “tyranny of niceness” (Walker, 1999)
- Professionally we have been traditionally an “overbounded” system but find ourselves currently in a new “underbounded” system (Alderfer, 1980)



Deciding how to communicate: understanding overbounded and underbounded systems

- In our former “overbounded” militaristic nursing structure communication lines were clear, albeit restricted
- However, innovation was not encouraged and authority relations were monolithic
- There was difficulty with openness and any problems would have been discussed clandestinely



Deciding how to communicate: understanding overbounded and underbounded systems

- Currently many nurses have clinical reporting lines to a doctor; Human Resource and/or operational reporting lines to a manager; and “professional” reporting lines to a nurse
- This lack of clarity in communication creates an “underbounded” system and often leaves nurses uncertain as to how to communicate most effectively to achieve impact or change
- Our sense of loyalty and possibly our sense of comfort keeps the nursing lines going but, unless the nurses can provide solutions and support, these communication lines become a problem, rather than a solution

Alderfer, C, (1980) Properties of overbounded and underbounded systems

Overbounded systems	Variable	Underbounded systems
Goals clear: priority unequivocal	Goals	Goals unclear: priorities equivocal
Monolithic	Authority relations	Multiple and competing
Minimal short-term stress	Economic conditions	Impending economic crisis
Precise, detailed, restrictive	Role definitions	Imprecise, incomplete, overlapping
Difficulties with openness when people meet	Communication patterns	Difficulties in determining who can and should meet
Constrained, blocked	Human energy	Diffuse, exhausting
Positive inside: negative outside	Affect distribution	Negative inside: negative outside
Organisational groups dominate	Intergroup dynamics	Identity groups dominate
Dependency	Unconscious basic assumptions (“as if”)	Flight-flight
Long	Time -span	Short
Single theory ideology	Cognitive work	Multiple or no theory ideology



Developing political capability and awareness

- There is a need for open and frank debate about big “P” and small “p” politics– first and foremost within the profession
- This debate needs to be fostered as a central part of nursing education and culture
- This will be good training for debate around boardroom tables in the future
- Then there is a need to develop a series of consensus strategies for lobbying purposes between professional groups and in coalitions



So how do we “debate” or at least respond to the difficult issues?

Ethos

of collective
non-
responsibility

Practice zone
of abrogation

**Ethos of
collegial
generosity**

**Practice zone
of
mutual trust
and
Collaboration**

Ethos of
Individual
accountability

Practice
zone of
isolation
or alienation



Encouraging debate and strategy

- Creating opportunities for inclusive debate about difficult issues
- Fostering our young
- Celebrating diversity, creativity and curiosity
- Knowing what we do and what we bring to the table
- Providing nurses with the language to discuss practice
- Developing a realistic sense of entitlement



10 Axioms for potential leaders (Diers, 2004)

- The universe is not random, nor arbitrary
- Money makes the world go around
- *Effective* gossiping is a secret leadership strategy
- If you're going to have the responsibility, take the authority too; or, if you don't have the authority, don't take the responsibility
- Power and influence are a lot of hard work



10 Axioms for potential leaders (Diers, 2004)

- Paranoia gives one as clear and true a vision of the world as politics or religion
- One who sticks one's head above the crowd will sometimes be a target
- Vision doesn't necessarily make a leader, but a leader without vision isn't
- Leadership in nursing can't be confined to nursing issues
- All weakness corrupts and impotence corrupts absolutely



In conclusion

- Nursing has the potential to take a strong and active leadership role in future health care delivery, despite current trends and prevailing mantra
- BUT
- We need to reconsider why leadership matters to us
- We need to re-conceptualise what our leaders might look like
- We need to decide and agree what we want nursing work to be concerned with
- We need to be able to strategise and manoeuvre and this requires language and models
- Thank you



References

- Adrian, A. (1999) Challenges for the nursing workforce in 2010: rethinking nursing. Proceedings from the National Nursing Workforce Forum, September 20-21, 1999.
- Alderfer, C.P. (1980), "Consulting to underbounded systems", in Alderfer, C.P., Cooper, C.L. (Eds), *Advances in Experiential Social Processes*, Wiley, New York, Vol. 2 pp.267-95.
- Chiarella M (2002) *The legal and professional status of nursing* Churchill Livingstone: Edinburgh
- Diers D (2004) *Speaking of Nursing...* Jones & Bartlett: New York
- Gillespie R. Handmaidens & battleaxes. ABC television program. True Stories. 10 June 1990.
- Pearson A (2000) The Joan Durdin Annual Oration. University of Adelaide
- Walker K. (1993) On what it might be to be a nurse: a discursive ethnography. Unpublished PhD thesis. La Trobe University