



if LEADERSHIP is the ANSWER, what is the QUESTION?

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WHEN BROACHING THE QUESTION OF leadership in nursing, it is difficult to know where to begin. At every turn there are textbooks, papers and journals devoted to nursing leadership. They describe everything from clinical leadership to professional leadership. Leadership programs offer nurses management training, political and policy training, and emotional and spiritual self-development, to name but a few. They target everyone engaged in nursing—from students in practical nursing programs to senior executives in major health care organizations. Suddenly, it appears, the lack of nursing leadership has been diagnosed as the major problem for the profession, and the whole world is working to turn each and every nurse into the leader he or she needs to be.

One problem with buzz words—such as “leadership”—is that they are parasitic. American president Theodore Roosevelt coined the term “weasel words” to describe these buzz words that colonize and then suck the meaning out of other words. Weasel words take over other terms, making them sound outdated; but as a buzz word grows in influence, paradoxically it loses meaning. A good illustration of this phenomenon is the rather irritating way that every salesperson is now a consultant. And somehow over the course of the 1980s, passengers and patients became customers and clients. Has the era of business-speak led to a radical improvement in the quality of services across the board? Hardly!

Perhaps we should examine our vernacular to identify what issues nurses need to address today.

The term “leadership in nursing” is also at serious risk of losing its meaning and power. Sometimes when we talk about nursing leaders what we are really talking about are competent practitioners, effective managers, innovative clinicians, resourceful advocates or humane professionals. In a world in which nurses frequently express concern that the public doesn’t understand what they do, it seems folly to collapse all of these attributes into the bottomless leadership bucket. One might wonder what the concept of leadership even adds to the discussion.

IT WASN'T ALWAYS THIS WAY

IN THE PAST, THE HIERARCHICAL INSTITUTIONAL structures and top-down leadership styles of the typical health care organization suppressed rather than supported its staff. An older colleague tells of her application to a prestigious nursing program in London, England, during the 1950s. During the interview, she was asked about her father’s employment. When she replied that her father was deceased, the nursing superintendent said coolly, “I didn’t ask you where he was, my dear, but what he did.” As late as the mid-’70s, one colleague bitterly recalls her first day as a nurse in a large hospital in Australia where the chief nurse “welcomed” the assembled

new staff with the admonition: “No one has asked you to come. If you don’t like it, you are free to leave.” I recall a small regional hospital where I worked (in 1990!) that was so bureaucratic that new staff members were expected to provide dental X-rays for the HR files. Apparently this was for identification purposes should we perish in a fire while on duty.

In these kinds of organizational cultures, leadership was defined by one thing only—where you ranked on the totem pole. Everyone from students to senior staff knew who was in charge of whom, and the organizational shape was a pyramid, with many foot soldiers and few officers. Instructions could not be questioned and initiative was synonymous with insubordination.

U OF T ALWAYS PRODUCED LEADERS

THE LEADERSHIP AND KNOWLEDGE required to transform the practice environment from such rigid origins grew through partnerships between the service sector and academia. U of T’s nursing school provided management training as a certificate program as early as the 1920s. We educated experienced nurses in the skills they needed to lead organizations, and we developed new programs, such

as the one in public health nursing. The grads of that program went on to develop public health services both in Ontario and across the country.

At one stage, our nursing graduates completed a five-year program that included basic nursing, management and public health. A good many of these highly educated nurses moved into major leadership roles in education, management and the community. New roles burgeoned for nurses with the postwar social welfare agenda as Canada struggled to meet the service needs of its growing population, and it was often U of T graduates who provided leadership in new communities across the country. With limited resources, our nursing graduates led initiatives to face new problems in a highly political environment.

These nursing pioneers would likely not identify with much of the contemporary discourse on nursing leadership. Often, these strong individuals were from an elite background and shaped by a set of values that saw leadership as one of the duties of privilege. Nursing leaders such as Agnes Snively, Kathleen Russell and Lyle Creelman were women

of their time, and Canada was fortunate to have had their leadership on both the national and international stage.

The democratization of the concept of leadership that revolutionized organizational culture in the second half of the 20th century was premised on the logic that engaged employees who are enthused about the company's mission are both more productive and more effective. Management science, organizational psychology and the rise of business schools provided the knowledge and impetus to institutions, industry and government to overhaul their work practices and to begin to think about human capital as a valuable, as opposed to disposable, resource. In health care, this evolution in organizational thinking represented a seismic shift—nurses had to be supported to do their work well for the benefit of the system.

NURSE LEADERS NEEDED

HOW FAR HAVE WE COME FROM THE DAYS when most nurses were simply expected to do as they were told without question and could 'leave if they didn't like it'? There is no doubt that much has

been accomplished. Nurses today carry enormous responsibilities from direct practice to organizational oversight in ensuring the health care system is safe and effective. Increasingly, frontline nurses are degree prepared and more knowledgeable, articulate and theoretically informed than their predecessors. Advanced practice nurses have supported and led the proliferation of complex programs of care across inpatient, ambulatory and home care settings. Effective organizations fulfil their quality and accountability mandates through the utilization of nursing expertise in patient safety, infection control, program management, mentorship and peer education.

Despite these gains there remains much to do. Twenty or 30 years on from the revolution in organizational thinking that hit health care, we are still grappling with the partial and uneven transformation of the organization of nursing work. The shortages of all kinds of nurses—novice, experienced, faculty, managers and leaders—continues today. Hiring practices are still not recession proof, despite the proven cost to the system that comes from staffing cuts and the subsequent staff shortages that limit the system's ability to meet demand in the long term. Nursing education remains significantly underfunded compared to other professional programs. And supported transition-to-practice programs for new graduates are not built into our health system budgets as they are in other professions and for nurses in other countries.

So what is the problem to which leadership is the answer today? If the answer is everything, perhaps we need to expand our vocabulary to better articulate the problems we need to address. After all, a sure test of leadership is the ability to name the problems—that step is a necessary prelude to confronting them. *~*

