CARING LEADERSHIP
CARING LEADERSHIP

VOICES OF NURSES IN ROYAL ROADS UNIVERSITY LEADERSHIP PROGRAMS

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Copyright © 2000 Royal Roads University
Leadership Programs Publications
Royal Roads University
2005 Sooke Road
Victoria, BC
V9B 5Y2
www.royalroads.ca

Canadian Cataloguing in Publication Data
Main entry under title:
Caring leadership
Includes bibliographical references.
RA971.C37 2000 362.1'068 C00-910674-X

ISBN #0-9687361-0-6

Editor: Michael Picard, Ph.D.
Cover and title page artwork © Miles Lowry

Printed in Canada.
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Preface

This work is the product of an exciting collaborative effort at Royal Roads University. The articles in this collection are foremost a collaboration between learners from differing years of our Master of Arts in Leadership and Training Program, many of whom have now graduated. It also represents the linkage within the Organizational Leadership and Learning Division here at Royal Roads. Thus a number of the authors originally were introduced to the University and the MALT program through our Creative Leadership in Health Care executive short program. In turn, this collection of their thoughts has been sponsored and shepherded by the Executive Leadership section of our division. The circle has been completed.

Most importantly however this work speaks to the universal themes of our leadership and learning programs at RRU – the need to imbue the principles of personal learning into one’s organizational practice and the value of effective and empowering leadership in achieving organizational and personal goals. Finally, this volume speaks to the fundamental intent and desire of all our leadership and learning programs – that is – to make a difference. The valuable insights and thoughtful strategies included here should surely have that effect.

May, 2000
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Caring Leadership: Voices of Nurses
in Royal Roads University Leadership Programs

FORWARD

Cathy Ferguson, R.N., B.Sc.N.
President, BC Nurses' Union

I am a Registered Nurse. Recently I went walking among the incredibly beautiful semidesert hills near my hometown, Kamloops, BC. It was a hot day. I took a shortcut, over a patch of open scrub. Sagebrush fragrance filled my thoughts. I marched carefully around the blooming cactus.

Suddenly, a feathered creature fluttered from a patch of wild grass barely two metres from my feet. The mottled brown bird hobbled away, another half metre. I froze. Sneaking my pack to the ground, I felt for a camera. The bird seemed injured. It hopped in pathetic effort. I stepped slowly back, and around, putting the sun to my shoulder, the lens to my eye. The bird jumped again, this time a little further away. I snapped a shot, moved parallel. Next, the bird flew into the air and then thumped to the ground, now ten metres away. Was I watching a baby hawk learn to fly? I felt like an intruder. Where was the mother?

I went to pick up my pack, just wanting to retreat. It was then I spotted the nest right in the grass where I had first seen movement. The bird was an adult, probably a burrowing owl, leading me away from her babies. But eggs were visible in the nest. That was odd, in June. I focused the zoom, and saw that the eggs were shells. Some hungry critter had sucked them dry probably months ago. I wept for my little friend's loss, and for her bravery.

Leadership lives within us all. Leadership is about learning, and it is about relationships between people. Everywhere: in Nursing Schools, Universities, the military, government, industry, business-effective leadership learning is done basically the same way. Students get together in groups, whether it be informal or formal, and they help each other. They swap ideas, explain
things, rely on one another. Long lasting, powerful bonds come out of these relationships. People grow to cherish the successes of their buddies. They want others to shine. “Leading by example” may be a cliche, but it is a true principle. Nurses do exactly that, all the time.

Relationships between people are the most important thing in life. It is out of those relationships that leadership comes. Leaders don't chase power, they end up with it. Look around and think who in your life, your workplace, your classroom, stands out as a leader. Ask yourself if that person likes to keep power, or likes to give it away. Ask yourself why. Think of the people who are in relationship with that leader. When those people lead, how does that happen, and why? Is there a difference or is leadership seamless?

Everyone is a leader, no exceptions. This isn't “feel-good talk”. This is valid thinking, and it shows up within the profession of Nursing everywhere, all the time. Individuals who emerge to lead us in ways that harness opportunities, forge new relationships, turn challenge to progressive change... they understand this. That is why this kind of leader always seems to be surrounded by other bright people who also lead. That is also why this kind of leader often isn’t around for very many years. Such leaders care about the fact that new leaders are always coming along. They naturally move on themselves. They build new nests.

I would like to thank Graham Dickson for the opportunity to write this piece. I am thrilled to know that so many of us have made time to focus on Nursing leadership. The work in this book is brilliant, and provides extremely valuable insight into this very important subject. Enjoy.
For it says a great deal about Canada that, unlike in the 1950s, your income is largely unrelated to the hospital and physician services you receive. It says that Canadians care. It says something that the notion of two-tier medicine rankles the public mind where ever you go in Canada. It says that Canadians are fair, that they care whether their fellow Canadians can get the health care they need regardless of the amount of money they make. Canadians know that how people in need get treated in Canada is vital to what Canada is, to the kind of society we are creating for ourselves. They know intuitively what McGill Professor Margaret Somerville recently said about care before a Senate Committee: “caring for each other is actually the glue, the existential glue, that holds us together as a society.” Continuing about the importance of health care to national identity in modern secular societies like Canada, she said:

health care is the societal institution that is most important in value-carrying, value-formation, value-promotion and, if it doesn't do those things well, value-destruction for the society.... The fact that Canada has always had such a strong emphasis that this is a publicly administered egalitarian system, and that there's been largely (to put it at its mildest) an inhibition of private care, makes it even more important in terms of those value functions at the society level as a whole ...

(Somerville, 2000)

It is often said that a society is best judged by the care it takes of its most vulnerable. While Canada can by no means pass this test in all regards, its treatment of its ill, by world standards at least, is reasonably good. We have a long way to go to eliminate inequities “both within and between communities across Canada” (CIHI, 2000, p. ix), to ensure equality of access to a continuum of care services in all areas of the country, and if possible to broaden the array of services in the Medicare basket. But it remains true that the crisis we are currently in is to a significant extent a consequence of our success (Somerville, 2000). We are in part victims of our excellence and our high standards, which is an enviable victim status if ever there was such a thing. This is in no way meant to minimize the problems facing us as we look ahead, but only to say that we need to move from strength to greater strength, preserving what works and expanding care as far as possible within the bounds of sustainability. The debate today is not about whether to make major changes, but the directions those changes should take. It is this that the public and the politicians, the pundits and the professionals are busy discussing at conferences, meetings and summits.

The essays in this collection add some voices to that debate, to the public conversation over the future of healthcare in this country, particularly in regard to the role of nurses in the design and implementation of the necessary changes. No grand solutions are proposed, and no final answers or technical fixes are advanced. What is here is a variety of voices speaking to an even wider variety of leadership challenges raised by the current health care situation. The voices are those of nurses who, for their own personal and professional reasons, have decided to undertake a serious and in-depth study of the concept of leadership. They have gone beyond the much-lamented lack of leadership in nursing and healthcare in general, and have asked what leadership means to them personally, to their co-workers, and in their world. The nurses whose thoughts are recorded here are all either enrolled or recently graduated from the Master of Arts in Leadership and Training (MALT) at Royal Roads University; some came to that program through executive leadership training in healthcare at Royal Roads. All are searching for ways to contribute not only to the public deliberations now underway, but to the gargantuan task of leading that change in effective directions. All share their reflections on what leadership can and must be within the nursing profession. Outnumbering physicians by four to one, and functioning in a wide variety of capacities and delivery points, working nurses are a significant part of the healthcare system. As such, they are directly experiencing no
small part of the problems facing us collectively. The essays in this volume speak to how nurses can and must take on leadership roles and identities in order to become major part of the solutions we seek as a nation.

In spite of the variety of themes and voices touched upon in this slim volume, there is a certain harmony among them. Some essays report on original research conducted in the major action research project that is a key component of the MALT degree program. Others speak more personally of their own evolving philosophy of leadership, inventing various conceptual frameworks and roadmaps that help them make sense of the nature and need of leadership in health care today. There is more than one unifying thread running through these essays — including the belief in human potential, the importance of a learning culture, the responsibility of listening, the insights of systems thinking, the inspiration of ethical principles and spiritual connectedness — but no single theme better represents the whole than care. The nurses' voices collected here unite in speaking for the fundamental ethical principle of care, and for its vital and driving role in motivational leadership. In the end, we lead because we care.

**Who cares?**

It goes without saying that nurses care. But how do we as a society take care of our nurses? This naturally becomes a critical question when nurses think about leading nurses. Indeed, “there's a keen sense among nurses that they've been taken for granted for decades” (Fletcher, 2000). But the question is particularly pressing today, since nursing, as the largest health care profession, is also the most stressed and unhealthy. According to John Millar of CIHI,

> there is a lot of stress in the system, particularly amongst nurses, where there’s very good data now that shows that, amongst all the workforce categories, nurses are suffering more time off, more disability, more back pain, more assaults, etc. etc., so that the

nursing profession is clearly suffering. It is also getting older.  
(Millar, 2000)

“People in other health occupations were about half as likely (4.8%) to have missed work” than full-time nurses, 8.4% of whom miss some work each week due to illness or disability (CIHI, 2000, p. 25).

Over the year, nurses lost over three weeks of work on average (15.6) days) due to illness and disability — more than any other group. Blue-collar processing workers and transport operators, the next highest groups, each lost less than ten days. The average for occupations in all sectors was 6.2 days per worker.

(CIHI, 2000, p. 25)

Fletcher (2000) warns of the dangerous consequences of not caring for what we value as Canadians:

Consumers and policy-makers alike concede nurses are key front-line players in the delivery of health care; they're typically described as the 'core,' the 'backbone.' The system's success depends, in large measure, on the job these people do every day. But an overextended system is far from foolproof, as too many health care users have discovered. Like a smooth, perfect white eggshell, nursing care can be strong and seamless — but put it under too much pressure and tiny cracks develop. Over time, the fissures multiply and the eggshell weakens, ultimately shattering.

(Fletcher, 2000)

From all this it is clear that the care of nurses is a strategic leadership issue for nurses. It is one that is contended with in several of the essays that follow, and stands in the background of all of them.
Another way that care for the caregivers is a strategic leadership challenge concerns the future of the nursing profession. Part of caring for nurses is looking out for future nurses, and that requires projecting self-care forward through enhancing education for young nurses as well as planning learning cultures in work organizations. Barb Wahl, President of the Ontario Nurses Association, explains the importance of dealing with the growing demand by forward-looking planning of the supply of educated nurses:

*we need improved care in the community, so we need to hire more nurses for home care; we need to have more nurses in nursing homes, and the reason for that is that by looking after people well in those settings they won't have to come to emergency. We need to have education, full tuition support for young people who are thinking about this profession, so we can get them in, and get them graduating before this nursing crisis peaks.*

(Wahl, 2000)

As mentioned above, the profession as a whole is getting older. Widespread nursing shortages and ongoing issues of education, recruitment and the improvement of learning opportunities for working nurses, are among the major leadership challenges that get the attention of contributors to this volume. Essentially, they call for an infusion of care into the culture of health care, care directed not solely at the patients but at nurses and other care providers as well. One part of realizing this goal is to ensure that health care institutions become learning organizations, which many of the papers call for. Just as care is the existential glue that binds us together as a society, so care in both the present and the projected sense acts as a quickener in the process of self-directed organizational change.

**Overview and outline**

I conclude this introductory essay with an outline of the book and an overview of certain theories taken into consideration by the contributing authors.

Our title essay describes a personal process of discovery which led one graduate to envision “a caring network of nurses” and to invent a means to “share nurses memories of caring and non-caring among nurses [and to jointly] imagine their desired future.” Dougherty sees care as a self-defining concept, and urges nurses to reclaim it for themselves: “The experts had turned nurses’ caring into their illness.” It is noteworthy that, even in this gentle story, there lurks a clear call — is it a demand? — for power, to “have power”, to rediscover a lost sense among nurses that they are already “powerful beyond measure.”

The link between the act of care and the act of leadership is also made in the second article by Dobbyn. Through focus groups she studied nurses in a transitional care unit as they grappled with their function and their future. Many of the nurses she quotes give moving testimony to frustrated care. As one participant simply and plaintively put it, “I would like to be able to have more time to show I care”. Citing Wheatley (1999), Dobbyn ends her essay by hinting at a theme that is much discussed in subsequent essays, that leadership is a function shared by all, not a position reserved for few.

Buckingham, another MALT graduate, conducted an appreciative inquiry to discover what “leadership looks like in the hearts and minds of public health nurses”. Her findings point to a definite and well-recognized approach to leadership within the attitudes and ideals of nurses, even those who did not self-identify as leaders. That approach is known a servant leadership, a concept rich in paradox and potential, but one with uncomfortable connotations for a profession conventionally cast in a subservient role. Going beyond terminology, Buckingham argues that the shoe fits, as it were, and calls on nurses to adopt a leadership identity and grasp the leadership opportunities that
abound around them. Her essay offers an excellent overview of ethics-based, transformational and servant leadership theories.

Gauthier presents a list of eight simple statements, elaborating on each to develop an ethics-based approach to leadership that urges leaders to listen, to believe in themselves and practice self-care, to take initiative and risks, to be creative, and to share the visioning process. She invites us to imagine with her a world where nurses are leaders in all these ways, where a culture of trust pervades the profession and the health care system. She is adamant that universal ethical principles underlie sound and sustainable leadership, and rejects the moral relativism behind contingency theories of leadership. The contingency approach to leadership ranks people and situations according to various criteria and prescribes styles of behaviour appropriate to each combination of variables. Different theorists used different criteria and defined the relevant styles in their own way, but the approach excluded apparent ethical principles in an effort to be scientific and value-neutral. In a simple example, a crisis situation may call for a more authoritarian or command and control leadership strategy, whereas less urgent situations may allow for more humanity. But since, as O'Toole (1995) maintains, "there is always a crisis", this theory in practice results in power-based leadership. Several authors in this volume join Gauthier in rejecting the contingency approach to leadership.

Andrews lays down five leadership challenges for nurses and for the health care professions generally. She argues that it makes good sense from a health care perspective to allow nurses a larger role in decision-making, more autonomy and authority, along with accountability mechanisms and learning support. Not only in the work environment, but also in the public deliberation process that will result in broad system changes, nurses need to have meaningful input into decision-making. If the love and labour of nurses is acknowledged and respected at the level of organizational culture, benefits will accrue not to nurses only, but to the health system generally. Given the great diversity of roles nurses play in a variety of capacities and situations, this is not hard to imagine.

In a personal essay, Faulds uses the gardener as an extended metaphor to share her insights on leadership. Gardeners nurture, guide and provide stewardship; they do not "command and control" the garden's growing. They look ahead and look back, they ask for help and learn from others including, apparently, ancient Chinese philosophers. In fact, Faulds is by no means the only contributor to this volume who has taken direction and guidance from the naturalistic mysticism of Lao Tzu or from other spiritual sources. Gardening becomes far more than poking about in the ground; it becomes a metaphor for the calm and compassion that still motivates leaders today. The symbol of the gardener suggests caring attention to the living and, at a more theoretical level, the concept of a living system from systems theory. Systems thinking is a holistic approach to understanding organizational life through connectedness and interdependency. Several authors in this volume make appeal to and use the concepts of systems thinking in their individual approaches to leadership.

Among those authors Byrnes treats the subject most extensively. Following Senge (1990), she takes systems thinking to be a key discipline of a learning culture. Systems thinking is a way of understanding organizational life holistically, of recognizing dependencies and interdependencies, of exposing counterproductive habit-patterns of thinking and behaviour. Byrnes describes a number of dysfunctional closed behavioural loops and offers insights to combat the culture of blame that can arise in a system nearing chaos. She draws heavily on chaos theory, a form of systems thinking applies to exceeding complex phenomena, such as life, weather and market fluctuations. Although chaos theory has a theoretical basis in mathematical physics, it yields pleasingly intuitive insights that speak to the nature of life and shared or social being. No two snowflakes are alike, for there is some randomness in their generation. But despite this disorder there are recognizable patterns in each
individual flake. Despite the patterns and cycles in the weather, no one can predict it. Chaos theory looks at the rise of simple and complex patterns from an underlying disorder or non-pattern. Byrnes in her essay urges nurses to see themselves as part of a larger web of life, interconnected and interrelated, facing common problems as a community of learning. She makes her theoretical considerations concrete in a series of challenging questions she leaves with the reader.

Hoffman takes up several of the themes already mentioned, and relates her own experience of an overly one-sided patient-centered model of care delivery. She rejects the view of leadership as purely positional, seeing it instead as the art of being oneself. Like many of her colleagues, she too sees the capacity to listen with empathy to others as a key leadership competency. She endorses systems thinking, learning from paradox, self-leadership and the empowerment of others. Calling on nurses to develop learning cultures, to promote creativity, risk-taking and change. Hoffman regards leadership as an art of inclusion. She ends her essays with suggestions drawn from her own experience and the themes of her discussion of principles.

As the final nurse contributor, Montigny shares with us a striking literary piece on leadership via the senses. Using the five sense modalities as metaphors, she explores vision (seeing), as listening (hearing), human contact and connectedness (touch), judgement and zest (taste), and a sense of timing and opportunity (which she compares to smell). But, playing on the traditional epistemic snubbing of the senses as modes of knowing, she cites a sixth sense, intuition, born of spirit or soul. She concludes by drawing out some implications of her thinking for nurse leaders.

The volume ends with an essay by Graham Dickson, Co-founder and Managing Partner of the Executive Leadership Programs at RRU. He explores the definitions of leadership, health and care, outlines seven concepts of leadership, and ends with some moving and hopeful suggestions for nurses who would be leaders.

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Angus Reid. Eight in ten (78%) of Canadians agree that the healthcare system in their province is currently in a crisis. Media release, Feb. 2, 2000.
URL: http://www.angusreid.com/media/content/displaypr.cfm?id_to_view=978


A nurse named Dorothy was working with a group of nursing leaders to develop their vision to be “a caring network of nurses” and their mission of “nurses supporting nurses.” They set about developing this network, this community of nurses. They hoped that this would strengthen them and give them ‘voice’ as leaders and then they would have power. However, journeys are never so simple and power does not come easily. They encountered resistance. Threshold guardians, wicked witches, and experts who suggested they were not leaders, they had no authority, they were ‘just nurses.’ Dorothy realized they would not survive in this old paradigm. A new way had to be found. The call to leadership, which is the first stage on the journey, begins with restlessness. Dorothy was restless. She enrolled at a school for a Masters in Leadership, believing that would make her a leader. The experts would show her the way, she would show the rest, then they would be leaders and others would listen.

At school (also known as Oz), Dorothy struggled with the predominant, western and masculine worldview where leadership is being ahead or in front, where leaders are authorities. She compared that view with her experience as a woman and as a nurse. This led her to the other worldview where leadership comes from within self, from within webs of inclusion, from a feminine perspective of silence, voice and shared authorship. Things began to fall into place. She began to connect her experience with this other view. Hadn’t nurses been talking all along of ‘finding their voice’? Why was it lost? The dream was
During the journey, Dorothy unleashed her personal leadership potential. She crossed the threshold and entered a new phase of her career. Dorothy left Oz and returned to Kansas, to the collective wisdom of the community of nurses who supported her and who grounded her. They reflected and shed light on her new perspectives. They were all in a process of transformation, seeking new ways of travelling this leadership road. She had just never seen it before. Dorothy still felt like an alien in the bureaucratic health care system among the many wizards who preach efficiency, evidence and outcomes. Something was missing. At times this alienation was like being lost in the dark or asleep in the poppy field in Oz. If not for the caring peers who surrounded her (the lion, the tinman, the scarecrow and others), she would have stayed lost. Instead, she began to make the connection between caring peers and leadership. She awakened, and the next path emerged.

Facing the shadow was the next phase on her journey. The shadow Dorothy had to face was caring and non-caring among nurses themselves. There was much talk of non-caring among nurses. They'd all heard it, they'd even said it “nurses eat their young.” There was also talk of over-caring among nurses, which supposedly led them into co-dependence and burnout. The experts had turned nurses' caring into their illness. This talk had extinguished the flame. Caring was what nursing was all about for Dorothy. It was why she went into nursing, it was why she remained in nursing. She began to wonder why nurse's caring had been silence. What were they afraid of? Her dream was to give voice to nurse's story of caring... and she did. She met with colleagues in Practice Circles® to share memories of caring and non-caring among nurses. In these Practice Circles® they experienced the power of storytelling to move them from silence to voice, to illuminate their experiences for shared reflections, and to allow them to imagine their desired future. Practice Circles® gave them three kinds of sight: hindsight, insight, and foresight.

They remembered... patients with uncontrollable pain, horrendous shifts, the death of those they had become attached to. They also remembered the actions of caring peers that carried them through these times, dear colleagues who went the distance with you, who noticed your pain, who called you at home and said “if you need someone to talk to I’m here.” They realized that when they worked with caring peers there was a huge sense of relief. They knew that, no matter what happened, they’d never be alone. They recognized how amazing the bond between nurses was. The Practice Circles® profoundly affected them. They recognized their vulnerability and the incredible effect that caring peers had on their confidence, competence and capacity as nurses. It was these relationships that allowed them to focus on the art and magic of nursing. It was this focus that made a difference to their patients. They discovered a caring cycle of light that moved them from connection to action to commitment. They acknowledged also the antithesis, the darker side of disconnection, inaction and detachment. They believed that Practice Circles® would ease the passage from shadow to light. They wrote their story and began to share it further, to foster caring from within the nursing community. They held circles with others around grief, change and hope. They rekindled the flame of caring leadership and passed it on.

On this journey, Dorothy came to know that caring leadership was nurse’s expertise. It was what made others fear them and their power. It was also what made nurses fear themselves. It was similar to what someone else had once said:

*Their deepest fear was not that they were inadequate (or uncaring). Their deepest fear was that they were powerful beyond measure. It was their light, not their darkness, that most frightened them.*

(adapted from Nelson Mandela’s 1994 inaugural speech, cited in (Rubin, 1997, p. 20).)
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She also realized that it was only from within a nursing community that authentic caring leadership emerged and was sustained. It was back home, in Kansas, amongst peers, that nurses found their voice and were no longer silenced.

The End.

References:

Note. For more information on Practice Circles® (the data collection method developed for the action research project upon which this story is based), please contact boisd@direct.ca or consult her Masters thesis (Dougherty, 2000).

Bev Dobbyn, R.N., B.Sc.N., M.A.

Caring: Who Takes a Leadership Role?

Leadership can be found throughout an organization. Leadership is not limited to one person in any work setting. It is based on relationships and actions, not on positions.

(Buzzotta et al., 1996)

In the course of a research project, staff members of the Transitional Care Unit (TCU), one of the in-patient units in the Capital Health Region (CHR), in Victoria, British Columbia, were invited to participate in two focus groups, proceedings of which were recorded on tape. During the analysis of the data two concepts emerged. The participants were demonstrating a number of leadership characteristics. More striking, however, was their strong commitment to providing a “caring” environment for the patients admitted to the unit. This essay discusses the analysis of the sessions and presents excerpts from the recorded conversations.

The TCU, a 57-bed unit, has been in existence since 1985. It provides care to patients predominantly over the age of sixty-five who no longer require acute care services, have unresolved discharge issues, and are waiting for placement in the community. The goal of the program is to maintain or improve the functional abilities of patients with a focus on quality of life issues. Although the stated focus and associated resources for the program have remained unchanged since its inception, there is a perception that patients transferred to the unit have more clinical needs and higher acuity levels than two-three years ago. This provided the impetus for the study which:

• described the care needs of the patients who are currently admitted to the unit and how these needs have changed over the last two years,
identified the program or service that could be offered by the unit to meet the current needs of the health region, and
determined what was needed to implement the recommended program or service.
(Dobbyn, 2000)

In answering these questions, the staff challenged the status quo, recognized the unit’s contributions and accomplishments, and initiated the process towards the development of a common vision for the unit— all leadership characteristics. Their words identified their deep conviction to caring.

**Challenging the status quo**

Staff of the unit were clear that the type of patients who were admitted to the unit had changed over the preceding two years. Initially patients were medically-stable, requiring discharge planning to prepare them for transfer to community facilities. This has now changed to patients who have a wider variety and higher level of care needs and who with complex discharge planning are more frequently discharged home. This is consistent with recent experience in health care across the country.

Staff identified the need to provide both physical care and emotional support. They listed their roles as that of communicator, advocator, mediator, educator, and supporter. They also expressed their frustration when they could not do so adequately:

There’s also the reality of the things that we can provide, which isn’t necessarily everything that the patient needs.

Staff emphasized the need to help patients deal with the losses they experienced when moving into facility placement:

And we are preparing these patients to go into the community, and that’s a big step for these people. It’s a huge thing. They’re giving up their home. They’re giving up their independence. The losses are very real for them.

The focus groups also brought to light the strong need to maintain the focus on quality of life, one of the core purposes of the original program:

A lot of times people come here and figure that some kind of miracle is going to happen, and that our function is to sort of add to the quantity of life. I think that our focus should be more on the quality of life. And that we should be decreasing the number of meds [medications] that they are on and doing things that actually make sense, like comfort. And, our resources are just wasted in med [medication] cups when you could take that [time] and put it into some sort of quality of life, have more volunteers, more functions, and more dignity.

(... this unit gets through a heck of a lot, and I think it’s just short on the caring. That’s on the caring side of all the things we do, the services and all. I would like to be able to have more time to show I care.

I think the nurturing. The people who come here have suffered a lot of losses; sometimes physical losses, emotional losses, social losses. And for them to continue to survive, they need to start healing here. They’re so fragile by the time they get here, they feel very deprived. They don’t know where they’re going, in any sense of the word.

The unit accepts patients predominantly from the acute care system, so that there can be a more efficient use of those beds. It therefore feels pressure from the acute care system to admit patients at a more acute phase, when there is a need for acute care beds:

There’s a big issue of communication between programs and I think sometimes there’s the pressure of
Recognizing the unit's contributions and accomplishments

The data showed that the unit has been very responsive to the needs in the acute care system. However, without established criteria, the unit at times seems to end up admitting anyone who does not meet the criteria set for other programs. As a result, the unit has been variously described in disparaging terms, like "catch-all," "holding tank," and "end of the road." For this reason, staff recommended that admission criteria be established.

In addition, the staff felt the TCU program lacked respect and recognition from others throughout the region's health care system:

- The in-depth assessment that is done here to address their needs as unique individuals does not exist in other places in the hospital, in the acute care hospital. A lot of things get addressed for the first time here, really addressed properly.

- I think we need more respect for our program, we need more respect from the community, from acute care, for what we do. Because we do an awful lot, and a lot of special things, and want to do it. And I think that everybody really has those patients' best interest at heart.

- (...) there's a lot of negative issues, there are a lot of things that we do well. We need to recognize that too. Facilities really like to get patients from TCU, because a lot of issues have been sorted out, resolved on TCU. And it's really a good preparation for what facility life will be like.

Transition takes a lot of caring and how do we get people to understand.

Developing a common purpose for the unit

Staff initiated the process of developing a vision or purpose for the unit. They did so by sharing their ideas and concerns, reflecting on what they had heard, and questioning each other until the redeveloped ideas made sense to them (Lambert et al., 1995). The visioning process occurred during the focus groups when participants were asked to identify the program or service that could be offered to meet the needs of the health region.

Staff had a difficult time defining what the specific program of the unit should be. They were reluctant to formulate inclusion and exclusion criteria for admission, even though they had identified the need for such:

- We need an identity for which we have control over. With the right to say 'no' (...) because right now depending on how tight beds are in acute, we have to take [whoever] they want to send us. We sometimes have no control.

Even though workload issues had previously been raised, there was a definite concern about what would happen to those patients who did not meet the new criteria for admission:

- (...) if we really get specific in [who] we are going to take, there will be a lot of people left out there (...) What happens to these people if we get that specific.

While we're looking at identity, I think we really need to be positive about what we can do and what we do do well, rather than not taking, rather than being able to refuse patients, rather than going there so much, as these are the ones that we can take. These are the ones that fit our criteria.

Staff noted a desire to have more authority to delay a discharge if the person was not fully ready:
We have to get people out, people get discharged home (... whereas before we were almost separated from acute care, we weren’t so subject to the pressures of acute care. Before we could keep people for three weeks to get them ready to go home, whereas now they are just shot out the door.

All staff felt that the program should have more than one focus. One of the components should recognize the staff’s existing expertise in caring for the older adult who is waiting for placement into a community facility:

Some beds dedicated to (...) patients [who] are deemed stable and need the support to get through to the period when they are going to facilities.

(...) people who are being assessed for long term care, they’re usually the people that every service starts to back away from in acute care. So they don’t start looking at what does this person need when they get into a long term care environment (...) and TCU is a very appropriate environment to start addressing some of those specialty needs for long term care.

Leadership and Caring

The focus groups provided the opportunity for the members of the TCU team to work toward the identification of a vision for the unit. It allowed the participants to reflect on what was attempted in the past, to determine what worked and what did not, and to generate ideas for further solutions. It demonstrated Wheatley’s (1997) leadership concept that, given the opportunity, “people [do] see what needs to happen, apply their experience and perceptions to the issue, find those who can help them, and use their own creativity to invent solutions” (p. 23). It demonstrated that nurses can and do function as leaders in their work environment.

The process also gave voice to the staff’s desire to maintain their caring values (Boon, 1998) and to serve their clients well.

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Caring Leadership: Voices of Nurses in Royal Roads University Leadership Programs

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What Does Leadership Look Like in the Hearts and Minds of Public Health Nurses?

Over the past decade, there has been a shift in the rhetoric about leadership in nursing. Early writings lamented the lack of leadership in the profession. This stereotype was reinforced by such statements as: “there is a shortage of leadership in practice: leadership observed, leadership experienced, leadership felt” (Mellicke & Larsen, 1992, p. 520); “community health nursing in recent years has lacked a cadre of highly visible and influential leaders” (Chalmers and Kritjanson, 1992, p. 166) and nursing has failed to produce effective leaders in sufficient quantities (Girvin, 1996). There were also calls for nurses to take on leadership roles and to “take a progressive, pro-active stance by initiating health care delivery changes” (Chalmers & Kritjanson, 1992, p. 166). Other scholars hinted that nurses are leaders; however their leadership skills are underrated and unrecognized especially by practitioners themselves (Sams, 1996). Norman (1994) challenged nurses to develop an ethos whereby leadership pervades the profession.

More recently nursing union leaders (Ferguson, 1999), professional organization administrators (Brunke, 1999) and scholars (Grossman & Valiga, 2000) have begun to articulate the view that all nurses are leaders. The Registered Nurses Association of British Columbia Position Paper entitled Nursing leadership and quality care (1999) suggests that we all are leaders regardless of where we work. Considering the scope of public health nurse practice this statement could not be more accurate. In fact, it is preposterous to think that a public health nurse could manage the following job-related tasks without leadership skills:
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- health promotion
- illness and injury prevention
- service provider
- educator
- consultant
- community developer
- facilitator

- communicator
- resource manager
- planner and coordinator
- team member and collaborator
- researcher/evaluator
- social marketer
- policy formulator

So what do we mean when we say 'We are all leaders'? Do we have a shared vision of what nursing leadership is? What leadership characteristics do public health nurses value? What does leadership look like in the hearts and minds of public health nurses? What enables public health nurses to lead?

A review of the literature on leadership theory reveals that there are more than 650 definitions of the word leadership (Bennis & Townsend, 1991), each with its own strengths and limitations. Much of the literature and research about nursing leadership focuses on the relationship between staff and management in hospital settings and little attention is paid to public health nurses. Many of these articles advocate transformational leadership (Barker, 1992; Barker, 1994; Bernhard & Walsh, 1995; Cottingham, 1994; Curtin, 1996; Davidhizar & Shearer, 1997; Dunham & Klahfen, 1990; McDaniel & Wolfe, 1992; Medley & Larochele, 1995; Morrison, R.S., Jones, L. & Fuller, B., 1997; Porter-O'Grady, 1994; Trofino, 1992; Trofino, 1995). Transformational leadership occurs "when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality" (Burns, 1978, p. 20). Burns believed that leaders "induce" followers to act where the wants, needs and expectations of both are congruent. Transformational leaders recognize the importance of followers and their need to develop their potential. They create a climate of trust and respect where followers can flourish.

Although this is interesting and informative on a theoretical level, one might ask what public health nurses actually do in practice? How do they lead in the nurse/client relationship?

In 1998, using an organizational development tool known as Appreciative Inquiry (Cooperrider & Srivastva, 1987), I collected the leadership stories of frontline public health nurses (Buckingham, 1998). Appreciative Inquiry is a form of action research based on a socio-rationalist paradigm (Gergen, 1982; Gergen, 1990) and is used to look at the 'best of what is' and 'has been' (Bushe, 1995). Grounded in their own experience and using their own words, nurses described their best leadership experiences and explored what leadership meant to them. This qualitative data was then thematically analyzed using Kirby and McKenna’s (1989) feminist methodology. Several themes emerged and it soon became evident that public health nurses view honesty, integrity and competence as integral components of leadership. They value energy, enthusiasm, drive, excellent communication skills, humour, assertiveness, inquisitiveness and a capacity to be reflective. Public health nurses admire the risk takers in the group and believe they excel as leaders when they have a passion for what they are doing and when they “stand up for what they believe in.”

The leadership characteristics identified during data analysis included:

- Commitment to individual growth
- Perseverance
- Facing oneself
- Awareness and Perception
- Reflection
- Persuasion
- Acceptance
- Empathy
- Listening
- Understanding
- Foresight
- Conceptualization
- Intuition
- Advocacy
- Empowerment
- Community building
- Putting others’ needs first
- Health/healing
These characteristics are strikingly similar to the characteristics of the servant leader (Greenleaf, 1970). Servant-leadership was first described by Robert Greenleaf (1977) in his 1970 essay entitled, “The Servant as Leader.” This style of leadership puts serving others as the number one priority. It “emphasizes increased service to others, a holistic approach to work and a sense of community, and shared decision-making power” (Spears, 1995, p. 4). Greenleaf (1977) described strong leaders as those who serve the needs of their followers by empowering (or enabling) followers to do their work for themselves. The heart of servant-leadership is devoting serious attention to doing our work in the service of others (Spears, 1995). There is therefore a conceptual as well as an empirical reason for the connection between the profession of nursing and leadership.

Larry C. Spears (1995), the Executive Director of the Greenleaf Center for Servant-Leadership, identified the following 10 characteristics of the servant-leader:

- Listening
- Empathy
- Healing
- Awareness
- Persuasion
- Conceptualization
- Foresight
- Stewardship
- Commitment to the growth of people
- Building community

Spears (1995) noted that this list is “by no means exhaustive. However, these characteristics communicate the power and promise this concept offers to those who are open to its invitation and challenge” (p. 7). It is remarkable that nurses described nine out of ten items in this list in the appreciative inquiry.


Max De Pree (1989) believed that, “The first responsibility of a leader is to define reality. The last is to say thank you. In between, the leader is servant” (p. 11). De Pree (1992) proposed 12 characteristics of a successful servant-leader:

- Integrity
- Vulnerability
- Discernment
- Breadth
- Comfort with ambiguity
- Presence
- Awareness of the human spirit
- Courage in relationships
- Sense of humor
- Intellectual energy and curiosity
- Respect for the future, regard for the present, understanding the past
- Predictability

All of these characteristics, if not essential, are certainly appropriate and very applicable to the practice of nursing.

Peter Block (1993, 1996) offered stewardship as his vision of a successful servant-leader. He defined it simply as “accountability without control or compliance” (p. xx). M. Scott Peck (1995) declared that any ethical leader will see himself or herself primarily as a servant of the group and will act accordingly. He pointed out that this is the essence of an authentic community. Peter Senge (1995) remarked, “For many years, I simply told people not to waste their time reading all the other managerial leadership books. ‘If you are really serious about the deeper territory of true leadership,’ I would say, ‘read Greenleaf’” (p. 218). This advice is equally suited for nurses.

Many of the public health nurses who were interviewed prefaced their leadership story with a statement that they weren’t really leaders, that they were just doing a job, or that their story wasn’t a real leadership story. However, each of the stories demonstrated that in fact nurses act intuitively as servant-leaders.
and clearly established that nurses are already leaders. The nurses’ leadership stories seem to indicate that nurses do share many aspects in their personal visions of leadership. The public health nurses’ preference for servant-leadership holds true whether talking about the relationships with clients and community, the relationships with peers, or the relationships with supervisors. Although public health nurses don’t seem to have a name for what they are doing, they are servant-leading. I call it ‘servant-leading by example.’

The public health nurses’ ability to lead has been enabled by a number of factors. These include:

- Communication and interpersonal skills
- A positive relationship with the community in which they work
- Positional authority (holding professional status)
- Political savvy (knowing how to get things done)
- Expert knowledge
- Opportunity
- Creativity
- Working for a servant-leader
- Flexibility (the ability to move into a leader or follower role depending on the need of the group)

Nurses often react negatively to the term servant-leader, equating it to ‘handmaiden’ or ‘servant’. Nurses are not doctor’s handmaiden, but we are altruistic and nurturing and we do help, serve and care for people and their health (Bernhard & Walsh, 1995). Although the name ‘servant-leader’ may not be ideal for nurses, we must go beyond the language and recognize that this model of leadership is entirely appropriate. Nurses must be reflective practitioners who can clearly articulate our leadership within the discipline and within the community. Stephen Covey (1994) believes that “the cultivation of the spirit of servant leadership will teach everyone to be kind, respectful and caring” (p. 3). To do this, we need to acknowledge that leadership already pervades the profession, and we must share our leadership stories with other nurses, the community, and our political leaders.

Servant-leadership is gaining momentum and is now being embraced by business as the new paradigm of leadership.

*It is not a quick fix approach. Nor is it something that can be quickly instilled within an institution.... At its core, servant-leadership is a long-term, transformational approach to life and work, in essence, a way of being that has the potential to create positive change throughout society.*

(Spears, 1995, p. 4)

The nursing profession developed as a service to society, so it is not surprising that nurses display the attributes of servant-leaders. In fact, nurses have a long tradition of servant-leadership and are in a position to “point the direction.” However, if as nurses, we do not understand and value our own leadership, how can we possibly have any real influence? Nurses are doing much more than “simply doing a job.” We are leaders and we must see ourselves in that role! There has never been a lack of opportunity to lead in nursing. We routinely assume leadership roles and positions. However, it is time for nurses to come to the realization that leadership is an integral part of nursing, so fundamental, in fact, that many nurses do not see it for what it is or call it by its name. We need to acknowledge and celebrate our leadership skills. We must be less self-effacing and acknowledge our considerable capacity to lead!
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Keeping It Simple – A Nurse’s Perspective on Leadership

Leadership is simple.
It is based on principles.
Leaders have personal vision and develop shared vision.
Leaders define reality.
Leaders are creative and not afraid of taking risks.
Leaders practice self-care.
Leaders start.
Leaders believe they can make a difference.
Leaders listen.

These simple statements express the evolving philosophy of leadership I have developed in my work as a nurse and through my experience in the MALT program. In this essay, I discuss each of them on their own and in application to nursing.

Leadership must be based on principles.

What are principles? Principles are “natural laws that are woven into the fabric of every civilized society throughout history and form the roots of every family and institution that has endured and prospered” (Covey, 1989, p. 33). Principles are permanent, enduring and unarguable because they are self-evident. Examples of principles are fairness, human dignity, growth, quality, service, potential and excellence (Covey 1989). Principles do not change over time or under different circumstances so no matter what the situation, “there is no
alternative to the practice of values-based leadership” (O'Toole, 1996, p. 79).

Principle-centered leadership provides constancy of vision. This is why contingency theory cannot work. Contingency theory is a prevalent approach to leadership that suggests that effective styles and behaviors vary depending on the situation. I agree with O'Toole who says “the moral and logical error inherent in contingency theory is relativism, the belief that there are no universal truths or objective knowledge save scientific proofs” (O'Toole, 1996, p. 98). “The moral error inherent in 'it all depends' is that there is no limit to it” (O'Toole, 1996, p. 105). A shining example of a principle-centered leader is Nelson Mandela. He was willing to compromise wherever necessary on tactics, policies, strategies but he never compromised on the principle of freedom and political equality.

Historically, the practice of nursing has been based on principles – specifically the principles of caring, advocacy, empowerment, human dignity, fairness, choice and excellence. As nurses move forward, we need to strengthen the basis of our practice which is caring. It is critical that we do not succumb to workplace pressures that have the potential to compromise these fundamental principles. Leadership based on principles is essential for nurses to function as independent, accountable professionals who meet professional standards.

**Leaders have personal visions and develop shared visions.**

Leaders have personal visions. Visions are conceptualizations of a desired future state. Covey’s (1989) first habit of personal effectiveness, “be pro-active,” speaks to the necessity of having a personal vision.

The leader is also responsible for ensuring that followers have personal visions and that these contribute to a shared vision. Senge (1990) describes shared vision as the answer to the question “what do we want to create together?” Shared visions are forces of impressive power. “People will not follow until they accept a vision as their own” (Kouzes & Posner, 1995, p. 11). As nurses, we must find ways to engage our highest aspirations in our collective work of caring. As simple as it may sound, the vision for nursing involves the provision of quality nursing care.

Of course, there is always a gap between vision and current reality. That gap can be a vital source of creative tension. Senge (1990) describes “creative tension” as an essential element of personal mastery. By its very nature, tension will always seek resolution or release – in this case either by pulling reality toward the vision or by pulling the vision toward reality. The nature of this tension underlines the importance of holding steadfast to a vision rather than compromising by bringing the vision closer to reality. Nurses must have the courage to envision a possible future and the self-mastery to make it happen.

**Leaders define reality.**

De Free (1989, p. 11) describes the first job of a leader as that of defining reality. Senge describes personal mastery as a discipline whereby leaders are “continually clarifying and deepening our personal vision, of focusing our energies, of developing patience, and of seeing reality objectively” (Senge, 1990, p. 7, italics added to original). Kouzes and Posner (1995, p. 283) describe research that has proven the positive effects of defining reality on motivation. Soldiers undergoing a forced march had the best performance and endured the most stress when they were kept informed by their leader as to how far they had gone and how much further they had to go.

Leaders define reality by providing feedback and information to followers. This exchange helps followers to understand where they are in terms of achieving the shared vision and provides everyone with an opportunity to review whether the vision...
remains appropriate and whether or not it is still shared. Defining reality is not a new concept for nurses. Communication skills are fundamental competencies required in nursing. Nurses are excellent communicators and understand the importance of sharing information not only with colleagues but with our clients/patients and their families.

**Leaders are creative and not afraid to take risks.**

Leaders are open to new ideas. They have their eyes on the horizon rather than on the bottom line. They are willing to look at things with a new lens rather than relying on the conventional attitude that prefers "the way we've always done it around here." Although creativity is never completely without risk, principle-centered leadership provides the solid foundation required to foster risk-taking.

Leaders encourage followers to take risks by providing safe environments that build trust. "Without trust and confidence, people don't take risks. Without risks, there's no change. Without change, organizations and movements die" (Kouzes & Posner, 1995, p. 12). Leaders learn from their mistakes. "Trust is built when we make ourselves vulnerable to others whose subsequent behavior we can't control" (Kouzes & Posner, 1995, p. 167). Without trust, we are inhibited by caution and suspicion. It is time to let go the aspects within the traditional culture of nursing that demanded perfectionism and punished imperfection. We need to work together to transform the culture in nursing from one of blame to one intent on working toward higher aspirations. Nurses need to strive to develop working relationships that create an atmosphere of trust and respect that will enable us to have the courage, commitment and creativity to challenge the system and shape the future.

**Leaders practice self-care.**

Covey's (1989) habit number seven, "sharpening the saw", is the principle of balanced self-renewal. Leaders balance and integrate personal and professional well-being. One of characteristics found in Helgeson's (1995) research was that the women she studied made time for activities not directly related to their work. "One cannot build a learning organization on a foundation of broken homes and strained personal relationships" (Senge, 1990, p. 312).

One of the most important things a leader can do is to practice and model self-care. This is especially true in nursing where caring for others is such an integral part of what we do. There is a pressing need in the profession of nursing to develop a culture that promotes self-care by nurses. This is not an easy task at a time when nurses are facing extremely difficult workplace realities such as staff shortages. Now, more than ever, it is vital for nurses to practice self-care and to promote self-care within the profession. It is time to take care of ourselves and encourage others to do the same.

**Leaders start.**

Health care organizations are becoming increasingly complex systems. Change happens slowly and even the simplest of ideas may take many months or years to come to fruition. This can lead to hesitancy, pessimism and a reluctance to initiate change.

Leaders take initiative. "Waiting for permission is not characteristic of people who get extraordinary things done" (Kouzes & Posner, 1995, p. 251). One of the challenges for organizations of the information age is to avoid "paralysis by analysis." It is imperative that leaders avoid becoming immobilized by complexity and the vast amount of available information. The adage "sometimes it is better to ask for forgiveness than permission" holds true especially for leaders. We must all be leaders and take the future into our hands. The time to do so is now. We need to embrace the courage to challenge the status quo and be architects of the future.
Leaders believe they can make a difference.

Leaders possess some common characteristics. Yukl (1998) describes these characteristics as self-confidence, internal locus of control, emotional maturity, integrity, socialized power motivation, achievement orientation and the need for affiliation. Kouzes and Posner (1995) say leaders are flexible, take initiative, and are able to learn and to conceptualize. They found that “leaders... committed to their lives, felt a sense of control over things that happened and experienced change as a positive challenge” (Kouzes & Posner, 1995, p. 71). Covey (1989) describes leaders as pro-active, willing to take initiative and able to make and keep commitments. Nurses are in a pivotal position to shape the future—we need to strengthen the conviction that we can change things for the better.

Leaders listen.

I believe that listening is the single most important activity of a leader. Another one of Covey’s (1989) seven habits of effectiveness is to “seek first to understand then to be understood.” While Machiavelli’s leadership is no model for nursing, even he recognized the importance of listening by saying that the prince “ought to question them upon everything, and listen to their opinions” (The Prince, ch. 23).

For many leaders, listening requires a paradigm shift. Traditional Western ideas have portrayed leadership as directing,commanding and controlling. Leaders need to let go of this way of thinking and to listen. The ancient Toaist sage, Lao Tzu describes the importance of “non-action” and of stepping back and allowing things to happen. “The highest type of ruler is one of whose existence the people are barely aware” (Lao Tzu, 1997, ch. 17).

Listening is not a luxury. I agree with O’Toole (1996) who rejects the idea that, under duress, a tough approach is necessary. There is no valid reason for not taking the time to listen. Leaders do not have the time not to listen. “How often is the leader the only one with sufficient information to make decisions?” (O’Toole, 1996, p. 87). Listening is not a new skill for nurses. Listening is integral to the caring relationships nurses develop every day.

Conclusion.

Trying to define leadership is a little like trying to provide a definition of “God.” There is no quick, steadfast answer and it is not for lack of trying. Most people define both in terms of their own philosophies and what makes sense to them from the descriptions of others. But there are some key elements that are likely to be found in any definition of leadership. I have attempted to describe the essential elements of my personal philosophy of leadership that I have chosen from a variety of sources to develop a framework that works for me. The fact remains, however, that leadership is impossible to define in any strict sense.

Definition may not be possible, but imagination is. Imagine a world where nurses work together towards the shared vision of quality nursing care. Leadership where relevant timely information is exchanged. A culture that fosters creativity and where nurses are not afraid to take risks. An environment where leaders promote and model self-care. Imagine leadership at all levels where nurses are empowered to make a difference. Imagine a place where the voices of nurses are not simply heard but where people take note and listen. Imagine a workplace where there are no concerns about quality of care. This is the world I imagine for nurses. If we all imagine it, it will not merely be possible: it will become reality. It’s just that simple.

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My personal approach to leadership has been shaped significantly by leaders I have admired from a distance and those with whom I have had the privilege to work. More recently, I have come to realize the depth of leadership research available and to a more theoretical understanding of how leaders have contributed to who I am and how I interact with others. Leadership is not about position, title or authority, rather it is about respect and acknowledgement, caring for and contributing to the development of others.

Fundamental to the practice of leadership is the understanding that “people are the heart and spirit of all that counts. Without people there is no need for leaders” (De Pree, 1989, p. 13) To be effective, leaders need to respond to the five challenges proposed by Kouzes and Posner (1995, p. 318). Leaders must: create clarity of purpose; challenge the status quo; enable others to act; model the way; and recognize and integrate the contributions of others. In the case of nursing, these practices are altogether too rare. All too often leadership is isolated in particular agencies, units and job descriptions.

Nurses are experiencing the direct effects of system reform gone wrong. There is a lack of consistent policy direction and a failure of alignment of purpose within the system. Additionally, politically-driven policies, including economic reforms focused on cost reduction, have resulted in continual instability for nurses. If the intent of the reform is the dismantling of the universal system of health, it is being achieved policy by policy. A recent report comparing Ontario to other provinces identifies Ontario at 33.8% as having the highest portion of health care costs funded privately, either through out of pocket expenses or through private companies (Daly, 2000).
What the nurses have been saying about the system reflects the problems of poorly designed change management, bad policy decisions and ineffective leadership. It recounts the fragmentation of the system, the erosion of the nursing profession, and the growing tragedy for the patient. Gordon (1997) details the detrimental effects of policy decisions on the nursing profession and health care. Referring to nursing as a "tapestry of care", she highlights policies that have contributed to the deliberate unraveling of the continuum of care with its resulting adverse effect on quality outcomes.

Gordon’s findings are confirmed in a 1999 study undertaken by the Ontario Nurses’ Association to identify member priorities (Ontario Nurses’ Association, 1999). The study found that nurses feel they have insufficient input into work reorganization and everyday decision making. They object that re-organization in the past has been unrealistic, inefficient, and top-down, based on old models and new management fads. They feel insecure, buffeted by events beyond their control, and lack due respect, support and acknowledgement for their contribution to the system. The research also confirms that nurses are withdrawing, both physically and emotionally, as reforms continue to dash their hopes.

At the system level, an overwhelming 92% of nurses said that the quality of health care has declined. Eighty-five percent said that government policy has had an unnecessary negative impact on health care, while 80% said that nurses have the knowledge and experience it takes to make the system cost effective and more productive, provided only that they are given the authority to make changes. Nurses agree the health care system needs to transform itself in order to meet the evolving needs of the patient. However, what they are experiencing is a reform that prizes cost reduction and administrative values more highly than the people providing the care.

As mentioned above, a major challenge and responsibility of leadership is to create clarity of purpose. Leadership is needed throughout the health care system to redefine the operative vision and mission, to advocate for the people providing the care, and to contribute to the creation of an environment that nurtures and supports its most valued resource. In the case of health care, the most valued resource is nurses. Research demonstrates there is a relationship between lower mortality rates and hospitals known to be good places to practice nursing (Aiken, Smith & Lake, 1994, p. 772). They found that the hospitals that nurses found desirable to work in are conducive to better patient care. The improved patient care resulted in a lower mortality rate in these hospitals compared with others where nurses were less respected. A renewed clarity of vision for the health care system must contribute to an organizational culture that acknowledges its most valued resource.

Creating clarity of purpose means developing a system mission that defines what employees and customers alike can expect from their interaction with the system. In the case of health care, that mission is the provision of quality health care. As Aiken and colleagues demonstrated in their research (1994), there is a direct relationship between the quality of the working environment of nurses and the health outcomes of patients. If so, then initiatives that indiscriminately reduce the number of patient days without input from the immediate care providers are bound to be contrary to the mission of the health care system. Involving nurses more fully in policy decisions that affect the quality of care will be indispensable for restoring public confidence in the system and meeting rightful expectations.

This brings me to the second onus on the leader: to challenge the status quo. It seems that the majority of leaders within the present system have lost sight of their purpose. It makes me think of the parable of the frog who, being unable to sense gradual variations in water temperature, was boiled before taking self preserving measures (Senge, 1990, p. 22). The leadership within the health system has become consumed with cost reduction and income regeneration due to increasing demand and amoral political agendas. Like the rising water temperature,
this process has been gradual, but it is slowly destroying the system of care. To reverse this decline, leaders within the system need to establish unit missions that give due respect to the importance of nursing care to the health outcomes, that eliminate time consuming activities extraneous to the mission of care, and that shift the role of supervisory staff from watchdog to support for nurses’ decision-making.

The third key leadership challenge is to enable others to act. Due to current pressures and strained resources, nurses and other health care providers are feeling frustrated, helpless and estranged. To overcome these feelings, leaders must invest time and resources in people to develop their skills, confidence, knowledge and their ability to be leaders themselves. To empower others it is also essential to ensure that there are systems in place to measure meaningful outcomes. While it may be important to measure patient satisfaction with “hotel services” (e.g. nutrition and housekeeping), I believe that there are more meaningful measures that need to be taken. Far more relevant for providers and patients would be measures designed to identify the incidents of hospital-acquired infections, patient injuries, treatment errors and the use of physical or chemical restraints. Data on these variables would better indicate the quality of care provided by nurses and reflect the cost of overworked care providers.

Enabling others to act is not an abdication of leadership: it empowers constituents and leaders alike. The leader must still “define reality” (De Pree, 1989); that is, establish the parameters of work and care. They must also model the way. Modeling the way is more than the latest jargon; it is not simply a slogan or empty words. Leaders need to demonstrate through their actions what is valued, desired and expected. They are constantly looking within themselves and within their organizations for improvement areas and for opportunities to implement corrective initiatives. Thus leaders need two types of plans: the first, a personal plan encompassing learning objectives, enrichment strategies and feedback measures; the second, work unit operational plans.

Work unit operational plans include feedback loops, dedicated budgets and schedules and other concrete measures to steer projects along predetermined courses (Posner & Kouzes, 1995, p. 13). Constituents need to know what operational plans exist and exactly how the work environment and quality of service is to be improved. They must be valued not only by being included in goal-setting and decision making, but by joining in the achievement and the accountability as well. Involving and supporting nurses in decision making is good strategy. Together with decentralized decision making and accountability mechanisms at the unit level for clinical nursing decisions, it contributes significantly to improvements in health outcomes (Aiken et al., 1994). Leaders who value the contribution nurses make to health care outcomes clearly model the way, and lead through respect and support the nursing profession.

In the case of nursing, perhaps the most important of the leadership challenges is the recognition and integration of the contribution nurses make to health care. This will only happen when administrators believe in the leadership and learning potential of nurses. In this there is some old advice that remains valid: “Give a man a fish and he will eat for a day but teach him how to fish and he will eat for a lifetime.” Nurses do not simply need a course for a day or other formal learning opportunities. These are important but more vital still would be the creation of a learning environment replete with informal and everyday learning opportunities for nurses. Nurses need the chance to come together to examine what is working, what is not, and what can be done more effectively. Only a learning culture can capture the vast collective knowledge and experience that is already there and turn it to the benefit of all health care providers and recipients.

The challenge for leaders within the health care system is the recreation of commitment and enthusiasm among the people affected most by reforms focused on reducing nursing costs. People do not feel valued. There is a failure of trust in leadership generally and the relationships with the system have been
severally damaged. What nurses are asking for is a chance to make real input before decisions affecting their practice are taken. If they have the opportunity, there will be direct benefits for all. All is not lost, there is time to embrace the challenges of leadership, demonstrate respect for the care providers, and contribute to the development of future leaders. It is all up to the leadership now.

References:

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The Leader/The Gardener

Ten years ago, Peter Senge introduced the idea of the ‘learning organization.’ Now he says that for big companies to change, we need to stop thinking like mechanics and to start acting like gardeners.

(Webber, 1999, p. 178)

The Leader/The Gardener

Senge’s metaphor encourages leaders to shift their thoughts of power and control to stewarding, guiding, and nurturing growth in organizations. This move is clearly towards a softer and more caring approach to leadership. While gardeners have many styles, they seem to have one thing in common: the love they freely give to the garden. As it happens, love has been identified as vital to leadership by influential theorists, Kouzes and Posner. They see love as the secret of successful leaders:

*When you are in love with the people you lead, the products and services you offer, and the customers and clients you serve, you just pour your heart into it.*

(1999, p. 150)

This makes sense to me because it is the same passion that I bring to my work as a nurse leader. With this passion I find I am increasingly able to weather the challenges of the leadership journey.

Nurse leaders, like gardeners, cannot live by love alone. They will also need to have vision and the skills to inspire vision in followers. Having vision does not mean the gardener or the leader relies on inspiration alone, or goes blindly forward on pure hope. Like the gardener, leaders need to understand the real world
threats, demands, risks and rewards, along with the adaptation that is required to ensure their endeavor reaches its potential. With the constant change in weather, the gardener needs to monitor, evaluate and reflect on the realities impacting the garden. This attention will ensure the garden is growing according to vision, with the leader making continual adjustments as needs arise and vary. Only through such attention can we reap and share the fruits of our labour.

Gardeners, like leaders, need to stay abreast of new and exciting trends and opportunities. Leaders, like gardeners, go outside of their garden from time to time to learn from the masters in their fields, seeking help with designing and redesigning a young or mature enterprise, to ensure growth continues and limits are respected. Neither gardeners nor leaders have all the answers. It is crucial therefore to look beyond our self and to learn how to ask for help. This is difficult but time honoured advice which one can find in the ancient and living Taoist philosophy:

Leading with the Tao is above all else a matter of character. It is transcending ego, looking beyond ourselves to find the lessons all around us. It means living our lives to make a difference, inspired by the strength and resiliency of nature.

(Dreher, 1996, p. 233)

The Seasons/The Systems

During the winter gardeners plan for the coming year. They order seeds, planting them inside where they are protected from the harsh elements. In this way gardeners ensure the seedlings grow strong enough to thrive in the external environment. The gardener is constantly renewing the garden by cleaning and by cutting back. The spring is an exciting time for the gardener as another clean up begins and it is time to assess which plants have survived the winter. The leader too must plan for the future, must protect new and fragile innovation, and make hard decisions based on enduring values.

The cycle of change is constantly repeating itself. The gardener knows this, as did the ancient Taoist sages who knew the nurturing power of the earth and the cyclical patterns of nature. In Tao the only motion is returning (Tao te ching, Ch. 40) The gardener-Taoist accepts the promise of nature, but in the end the garden deserves the credit for its beauty. The gardener is a silent partner. Lao Tzu’s thoughts on the subtleties of leadership ring through the gardener metaphor:

Rear them, then feed them.
Rear them, but do not claim them.
Guide them, but do not lean upon them.
Lead them but do not manage them.
This is called the mysterious power.

(Tao te ching, Ch. 10)
Free translation based on (Wilkinson, 1997)

Following the concepts of Tao, I am beginning to understand the complexity of organizations. I believe further learning is needed to view them as part of nature, not as something that is separate and artificial. Organizational theorist Margaret Wheatley (1999) provides hopeful examples of organization in both people and nature, and urges leaders to learn from system thinking, examples of self-organization and further learning about systems. I believe that in our search for a simpler way to lead organizations we can find answers in lessons from nature. The gardener does not exist in isolation from nature, as leaders cannot exist in isolation from organizations. If leaders act as gardeners, they will view organizations as “living systems” (Webber, 1999, p. 184). Ensuring that systems thinking becomes a norm in organizational processes will enable leaders to adapt and change with sufficient flexibility to fulfil their mission.
The Journey/The Change

If gardeners understand living systems, they will make connections with the past growing seasons, recognizing where the plants are now and what growth can be realistically envisioned. Like gardeners, leaders cannot reverse what has happened in the past to their organization. Both groups need to reflect on the past and learn what needs to be preserved and what needs to be changed. Before forging forward to implement change, the leader needs to understand the readiness of the organizational culture for change. Like the gardener awaiting the spring thaw, leaders must be patient. It will take time to empower people who want to move to a place where everyone shares responsibility for the organization.

Gardeners need to be patient in the summer, letting the plants grow, just as leaders need to have faith in people and in the process. A hard lesson I have learned is that there is a time to act, a time to pause, a time to reach in and a time to reach out. It is this learning and the guidance of a leader’s intuition that will enable them to successfully respond to the unforeseen challenges.

The gardener-Taoist knowing that one season leads to another enables them to smile at challenges, realizing there is always an answer to every problem, even if I cannot see it yet. Within every crisis lies an opportunity. I am concerned that, as nurse leaders, we are too impatient with all the problems in health care today and are too eager to solve them quickly. No one can fault our good intentions, as we want to improve things now. Our world has reinforced quick fixes and instant solutions. Timing is crucial, as the Taoist advise us:

*The wise leader knows when enough is enough.*
*Stretch a bow too far And it will snap.*
*Sharpen a knife too much*

I believe it is time for nursing leaders to heed this advice, to take time to step back, take stock, and begin a new cycle. This is the lesson of the gardener guiding us through the journey of reflection, asking the questions:

What worked?
What didn’t?
What could have been done better?
What are some specific suggestions for improvement?

Like the gardener, leaders need to include this learning as they plan for the future.

The Values/The Learning

To ensure our plans for the future are successful, our leaders, like the gardener-Taoist, must adopt a philosophy of growth. Nothing ever remains the same. Nature teaches us that any healthy system must grow and develop. A potted plant that outgrows its container languishes and dies because it has nowhere else to go. This is reflected in health care as nurses are confined into rigid roles in unhealthy, dysfunctional or addictive organizations. Perhaps the darkest cloud on the horizon in health care is the shortage of nurses. Nursing has become a very unattractive career where nurses themselves discourage students from entering the profession. As we face a nursing shortage and health care funding cuts in Canada, nurse leaders must take up the challenge and develop a vision for the future that reflects
Senge’s metaphor encouraging us “to stop thinking like mechanics and start acting like gardeners” (Webber, 1999, p. 178). My personal vision is that leadership must enable people to thrive, grow and fulfill their dreams in the workplace. This is the kind of leadership nurses need to address the problems of the profession.

As a nurse leader, I assume that people are inherently worthy and that they come to work to do a good job. Leaders must demonstrate a fundamental respect for all people, they must acknowledge and celebrate diversity, and they must listen without judgement. The application of values-based leadership allows for open, honest dialogue that builds respect for people and results in individual and organizational learning. Belief in people encourages them to transform themselves through learning. I believe that as a nurse leader I have a responsibility to enable people to learn by applying value-based practices. Encouraging the heart is indispensable for leaders who desire the cultural changes that the nursing profession so desperately needs to thrive.

Respect for others is shown by genuinely relating to others from one’s heart, rather than only from the head. Respect for self is shown by listening to one’s own inner voice. Living with respect unites our hearts with nature and the way of Tao. Thus like the gardener-Taoist searching for the hidden roots choking the growth of young plants, the leader too will need to prune their roots, assess choices, renew priorities, making the necessary cuts to allow room to grow. The gardener-Taoist reminds us that leadership involves a lifelong commitment to self-mastery:

Analyzing others is knowledge.
Knowing yourself is wisdom.
Managing others requires skill.
Mastering yourself takes inner strength.

(Tao te ching, Ch. 33; from Dreher, p. 71)

Self-knowledge is an essential value, since at the core of respect for others is the respect for self.

Looking Forward/Looking In

“If you use a living-systems lens, you get leaders who approach change as if they were growing something, rather than just ‘changing’ something” (Webber, 1999, p. 184) The garden has no tops or bottoms. The gardener is not in charge of the plants, controlling their work. The gardeners see the garden as a living system they can encourage, support and guide. If they leave a solid foundation in the garden, a new gardener can take over and continue the care the garden requires to move to the next stage of growth. After all, the long-term fruitfulness of our labour is our prime objective. The garden grows on after the gardener leaves; so too the leader must plan with an eye to the time when they will no longer be present. As nurse leaders we have a solemn responsibility to leave a plan and a strong foundation for nurses to continue the journey of transforming and developing the health care system.

References:
URL: http://www.fastcompany.com
Health care organizations must become learning organizations

Organizations are the people that work in them (Pfeffer, 1998). Each of us works in a health care organization of some description. Nurses do not work in isolation. We work with other disciplines and health care workers. Therefore to look at creative ways of solving the health care problems that are plaguing us today we need to work with other disciplines and health care workers. We need to create learning organizations.

Learning organizations are a product of the people who work within them. People in learning organizations learn with the organization and learn in relationship to others. To do so they need to exhibit a set of competencies that have come to be seen as part of emotional intelligence. In his highly influential book Working With Emotional Intelligence, Goleman (1998) found the following skills and behaviours to be highly sought after by organizations looking to hire:

- Listening and oral communication...
- Adaptability and creative responses to setbacks and obstacles...
- Personal management, confidence, motivation to work toward goals, a sense of wanting to develop one’s career, and take pride in accomplishments...
- Group and interpersonal effectiveness, cooperativeness and teamwork, skills at negotiating disagreements...
Effectiveness in the organization, wanting to make a contribution, leadership potential...

(Goleman, 1998, p. 12-13)

These are just the competencies needed in the learning organization setting. They will assist people as they move forward to strive to find new approaches to knowledge, learning and to today's health care issues (Barker & Camarata, 1998; Cole, 1998).

Becoming a learning organization is critical for creating the futures that we want. Fundamentally the concept of the learning organization is a concept of self-renewal. The complex capacity of a system to create, to self-renew and be generative, has been investigated in a new way by chaos theory, which provides a perspective in what follows. Learning requires an openness to change and feedback that is difficult to find in the turbulent and highly pressurized kind of environment typical of health care today. Learning also takes time, and people perceive that they don't have time. Responsibility and accountability for learning on the part of both the individual and the organization are essential to a learning organization. There is also a feeling that there is not enough money for education or training. In an environment of cutbacks, that means education is easily set aside. The following quote reflects the powerlessness and helplessness felt by people working within health care today:

Helplessness, the belief that we cannot influence the circumstances under which we live, undermines the incentive to learn, as does the belief that someone somewhere else dictates our actions.

(Senge, 1990, p. 287)

In spite of the conditions of uncertainty, a learning organization supports creativity, innovation and risk taking. A learning organization and its people learn by the mistakes that are made (Senge, 1990; Yukl, 1998; Senge et al., 1999). This has always been an especially hard lesson for health care professionals to come to terms with. This essay considers a number of other hard lessons of learning facing us today.

In health care organizations service is the product. The work carried out within them is increasingly knowledge based, therefore employees will always need to approach their work differently than they have in the past. Employees will need to view continuous learning as a way of keeping themselves current and marketable (Secretan, 1997; Gelatt, 1998). They will need to change their "underlying attitudes, values and beliefs about work and lifelong learning" (Barker & Camarata, 1998, p. 14). In keeping with this, learning organizations have been "characterized by knowledgeable, interdependent, human communication networks necessary to achieve the organization's fundamental mission, goals, and objectives" (Barker & Camarata, 1998, p. 15). Learning is a shared responsibility, a partnership, between employees and the organization they work in (Secretan, 1997). It must also be a shared value embedded in the culture of the organization and the people within it.

**Disciplines of Learning Organizations**

What will set learning organizations in health care apart from traditional health care organizations? The people within learning organizations who work on and become masters of specific, necessary learning disciplines. As identified by Senge (1990), these learning disciplines are: systems thinking, personal mastery, mental models, building shared vision, and team learning. With these disciplines established, a learning organization becomes "a place where people are continually discovering how they create their reality (and how they can change it)" (Senge, 1990, p. 12). To master these disciplines it is critical that the principles of the disciplines be understood. It is of course also necessary for the disciplines to be put into practice, to be carried out by the people who make up the organization. The more the principles are understood, practiced and integrated into personal and organizational life, the more they become a way of being (Senge, 1990).
I have a little to say in this essay about each of the five disciplines, but my main theme is the application of systems thinking, including “chaos thinking”, to the health care situation. I firmly believe this way of thinking will provide numerous insights for nursing. This way of thinking challenges the status quo. It challenges our view of what is causing the problems and issues faced in health care today. It also challenges us, as nurses, to determine what our roles are in perpetuating the status quo and the problems and issues faced by the health care system today. Some of these are hard lessons to be learned, but they need to be learned.

**Systems Thinking**

The systems thinking discipline is a “conceptual framework, a body of knowledge and tools” (Senge, 1990, p. 7). It is indispensable for understanding one’s role in a learning organization. Senge (1990) views “systems thinking” as the learning discipline that integrates and melds the other disciplines together. Therefore in this essay it is discussed to a greater degree than the other disciplines. All learning disciplines must be present and develop together within a learning organization. One learning discipline depends upon other learning disciplines for its definition and place within a learning organization. They complement each other and one cannot stand alone without the other. Together they are synergistic and can propel an organization forward in learning. This holistic packaging of the discipline is already an exercise in systems thinking.

With the development of systems thinking in a learning organization, people are able to see the impact of external and internal change on their environment. They are able to see that issues or problems are not the fault of one person or department. They are able to realize their role in the development of the issues or problems (Senge, 1990). The concept of everyone being part of the problem, of the blame not being one person’s or one department’s, is integral to working toward positive behaviours within the health care system. Systems thinking enables one to see the whole and where one fits into the whole. It enables one to pass on one’s knowledge within an organization so that looking at systems and the way they affect us and our work becomes a shared way of life (Senge, 1990; Gelatt, 1998).

Chaos theory – despite its terrifying name – is a kind of complex systems thinking. In fact, it is a theory that excellently describes the environment within which health care is operating today. According to chaos theory, the health care organization can be viewed as a living organism. It enables one to see the larger organization as a living organism made up of people and processes which are themselves complex organisms within a yet larger organism/organization. The individual is a complex/adaptive system within a unit/department, which is a complex/adaptive system within an organization, which is a complex/adaptive system within the health care system, and so on. This is the nested systems concept from chaos theory. The living organism lives in an environment that is itself alive and very dynamic:

*...we can forego the despair created by such common organizational events as change, chaos, information overload, and cyclical behaviours if we recognize that organizations are conscious entities, possessing many of the properties of living systems.*

(Wheatley, 1992, p. 13); see also (Capra, 1996)

The impact of organizational change is being felt throughout health care. Our ability to be able to respond to organizational change is important because we are going through it constantly. It will not go away. The need for and rate of change is increasing in response to advancements in health technology and customer needs. Because things seem to be out of control or beyond control, there is a felt need for command and control leadership that drives people within an organization in the opposite direction to what is needed (Kelly & Allison, 1998; Senge et al., 1999). In contrast, it is fundamental to chaos theory that an organization
maximize its ability to be flexible and adaptive in the face of constant and rapid change.

Relationships are an important concept of chaos theory (Wheatley, 1992; Capra, 1996). “Relationships are the essence of the living world...” (Capra, 1996, p. 173). To be effective these relationships must reflect the interdependence and interconnectivity we have with each other. This interdependence and interconnectivity enables an organism to be responsive, flexible and adaptive to its constantly changing surroundings (Wheatley, 1992; Capra, 1996). Another important concept of chaos theory is the ability of an individual cell within an organism to have the potential or energy that enables the organism to further enhance its responsiveness, flexibility and adaptive behaviour. According to chaos theory, everything within a system has the capacity of renewal and autopoiesis because the system is made up of living organisms (Wheatley, 1992; Capra, 1996).

The application of chaos theory (or complexity systems thinking) is particularly important in identifying the presence and subsequent impact of dysfunctional, closed behavioural loops within a department, and within an organization. These loops become reinforcing negative spirals or vicious cycles of behaviour that can lead to a pervasively negative environment, one where staff are so caught up in their own dilemmas, circumstances and negative reception they feel they receive as they carry on their work, that they in turn project negatively onto others, including their patients (Kelly & Allison, 1998; Senge et al., 1999). In this environment blaming becomes a way of doing business. Peter Senge’s (1990) “there is no blame” would not be easily understood or even conceptualized in such an environment. What we are seeing today in the health care system is a culture of blame together with the telltale drain on the physical, emotional, and spiritual energies of the individuals working in it.

It is my belief that the inability of the health care system to meet the needs of users today is the result of this system being driven by dysfunctional closed-loop behaviours. These loops are interlocking and reinforcing and cause the formation of vicious cycles of behaviours (Kelly & Allison, 1998). These vicious cycles waste energy and resources in a system of finite capacity. They are perpetuated by “victim behaviours” at all levels in the health care system and by all stakeholders within it. In a victim feedback loop, individuals may:

- ...feel helpless (no free choice)
- resign (themselves) to let others choose
- ‘comply’ with the choices of others
- suffer the consequences and blame others for emergent ills.

(Kelly & Allison, 1999, p. 53)

Dysfunctional closed behavioural loops are fueled by “fear, limited learning, shallow commitment and irresponsible interaction” (Kelly & Allison, 1998, p. 55-60). Without changing this, nurses cannot change nursing.

Recognition of each of our parts in perpetuating these cycles needs to occur. Each of us needs to recognize our role – blame should not lie with one person, one discipline, one department or one institution (Senge, 1990). Until recognition of and dismantling of these behaviours occurs within the health care system we will continue to lose energy and resources (Kelly & Allison, 1998). We will continue to work together dysfunctionally.

As elements of the health care system, we need to work at developing functional closed behavioural loops and autonomous individual behaviours. Both are perpetuated by the energies of trust, deep commitment, shared learning and responsible interactions. These positive energies create behavioural loops that are interlocking and amplifying (Kelly & Allison, 1998). Individuals in a functional environment of “rapid change and competitive pressure” for an “autonomous (individual) feedback loop” (Kelly & Allison, 1998, p. 66) must:
...understand (the) urgent need for and have confidence in their contributions
- participate in surfacing options and making choices
- take responsibility for (their) own decisions and consequences
- share impact of mutual choice and inevitable co-evolution.

(Kelly & Allison, 1998, p. 66)

There is a great need within the health care system for leadership that is able to recognize victim behaviour, dysfunctional closed behavioural loops, and the havoc these behaviours cause on our ability to provide health services. Leadership of this type needs to be practiced by stakeholders at all levels within the system before we can move towards functional closed behavioural loops and autonomous individual behaviours (Kelly & Allison, 1998).

This type of leadership begins with the self. Changes must first occur within the self before they can occur at any other level in the health care setting. Leadership means embracing all the learning disciplines, but it starts by developing personal mastery.

Personal Mastery

To embrace the discipline of personal mastery in a learning organization one must become “committed to lifelong learning” (Senge, 1990, p. 7). One must be able to look at reality objectively. One works on defining and delineating one’s own personal vision. One lives one’s life in the “service of one’s aspirations” (Senge, 1990, p. 8). In respect to the individual and the learning organization, it is important that personal mastery strive to align one’s own personal vision with the vision of the learning organization (Senge, 1990). As nurses, do each of us have our own personal vision for the work we do? And does our personal visions for the work we do align with the that of the organization in which we work?

Mental Models

In respect to the discipline of examining our mental models, it is important to develop personal reflection at the individual level as well as at the collective level. It is important to discover and know what our views of the world are. It is necessary to bring these views out in the open to have them out there for all to see (Senge, 1990; Gelatt, 1998). This discipline requires the use of dialogue, which is:

...the ability to carry on ‘learningful’ conversations that balance inquiry and advocacy, where people expose their own thinking effectively and make that thinking open to the influence of others.

(Senge, 1990, p. 9)

This requirement ensures that effective and meaningful dialogue goes on around issues and areas of difference amongst the parties involved. In a learning organization dialogue cannot hinge around “winning at all costs”. Dialogue can be effectively used to air differences and to ensure that all points of view are heard (Senge, 1990; Spears, 1995; Easterby-Smith, Snell & Gherardi, 1998). Dialogue ensures the building of shared language and shared meaning among all participants involved within the health care system. By exploring personal and collective mental models through the use of dialogue the building of shared vision occurs.

The leader as a teacher needs to be able to define reality, to challenge and enlarge mental models. In the reality of health care today, this may include unfair perceptions of negativity and the negativity itself. The leader can “influence people to view reality at four distinct levels: events, patterns of behaviour, systemic structures and ‘purpose story’” (Senge, 1990, p. 353). Even though leaders are aware of all four levels, their primary focus is on the organization’s purpose and systemic structure. They influence people throughout the organization to do likewise. Knowing the systemic structure enables the leader to help people to focus on and see the big picture—the whole of which they are
living parts. It is vital for people to see and understand how “systemic forces can shape change” (Senge, 1990, p. 356). The organization’s purpose story, on the other hand, enables people to understand what we want collectively to become. Thus the leader as teacher fosters learning throughout the organization.

**Building Shared Vision**

Building shared vision within a learning organization requires the skills to develop a picture of what the future might look like and how we are going to get there. The discipline of building shared vision entails engagement and commitment on the part of those involved, rather than just compliance (Senge, 1990; Gelatt, 1998; Yukl, 1998). Building shared vision is in essence building a shared future.

The leader as steward has a purpose story that is both personal and collective. It is the mainstay of the leader’s ability to lead. “The purpose story [is] a larger ‘pattern of becoming’ that gives unique meaning to (the leader’s) aspirations and...hopes for their organization” (Senge, 1990, p. 345). The leader must be able to tell and to demonstrate their own personal purpose story. Their personal purpose story should meld with the purpose story of the organization. Our shared story enables us to see our past and our future and how we have moved from the past and are moving into the future. It gives us a set of ideas that integrates meaningful into all aspects of our work. Properly integrated, the leader’s vision is the vehicle for advancing the organization into the future. The pull can be so strong that the vision becomes a calling (Senge, 1990; Schweitzer, 1998; Yukl, 1998).

...the power of the purpose story...provides a single integrating set of ideas that gives meaning to all aspects of the leader’s work...He or she becomes a steward of the vision.  

(Senge, 1990, p. 346)

In the health care setting, do we as nurses each have our own personal purpose story? Is the purpose story personal and collective? Is it an integrated vision that gives each of us meaning in all aspects of our work? Does it have a pull that will assist each of us and our organizations to advance into the future? Are we stewards of our organization’s vision?

**Team Learning**

In the discipline of team learning dialogue is “the capacity of members of a team to suspend assumptions and enter into a genuine ‘thinking together’” (Senge, 1990, p. 10). “The purpose of dialogue [is] ‘seeking mutual understanding and harmony’” (Yankelovich, 1999, p. 14). The discipline of team learning enables one to recognize patterns of communication within a team that may be negative or defensive. These patterns may be engrained from long periods of use without being challenged. They are counterproductive and hinder learning. But if negative patterns are surfaced creatively through dialogue, they can actually help the learning of the team (Senge, 1990; Cole, 1998; Easterby-Smith, Snell & Gherardi, 1998).

Dialogue is neither easy to understand nor easy to do...(dialogue is) difficult to do well, and it isn’t done well very often.  

(Yankelovich, 1999, p. 19)

Dialogue is a form of communication. It is not mere conversation and it is not debate. It takes knowledge of what dialogue is, as well as practice doing it, before it can become effective for team learning (Yankelovich, 1999). There would be a great advantage in the health care setting if dialogue was practiced.

In our health care organizations, have we as nurses been part of a team learning experience where there was “the capacity of members of a team to suspend assumptions and enter into a genuine ‘thinking together’” (Senge, 1990, p. 10)? Do any of us know what this sounds or feels like? As nurses, have we observed in the organizations where we work negative or defensive patterns of team communication? What were our roles in perpetuating
these types of communication? How can we change this? Do each of us have patterns of communication that have been engrained from long periods of use that are counterproductive and hinder learning? What are we doing to surface them in dialogue?

In Conclusion

As nurses, are we ready to meet the challenge of the learning disciplines? Are each of us, as the singular elements within a living system able to adapt and to survive in the uncertain environment of chaos and constant change facing us? Are we preparing ourselves for self-renewal and autopoesis? Are we flexible, creative, and not afraid to take risks? Do each of us learn by our mistakes? Are we building the relationships that are needed in an environment of chaos-relationships of interdependency and interconnectedness? Are we prepared to transform ourselves-to change? Is each of us able to see our role in the development of problems and issues? Is each of us able to see the whole and how we fit into the whole? As nurses, are we prepared to assume the roles of leader, teacher and steward in the organizations we work in? Is each of us able to recognize victim behaviours in ourselves and in others? Is each of us able to promote autonomous individual behaviours in ourselves and to support the same in others? Is each of us able to recognize dysfunctional closed behavioural loops and realize the amount of energy and resources wasted in maintaining these patterns? Is each of us able to recognize functional closed behaviour loops and to realize the positive energy that these generate?

If we can each answer “yes” to these questions, then we are in the process of building learning organizations. We are in the process of becoming able to meet the needs of the clients we serve. Since we are the organizations we work in, we alone can change the direction of health care. The task will not be easy, but I hope I have been able to outline some of the first steps of this important process in this essay.

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Caring Leadership: Voices of Nurses in Royal Roads University Leadership Programs


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The Quest for Shared Leadership

1. Leadership begins with self.

Leadership is not a position but rather a performing art, not a theory but a “collection of practices and behaviors” (Kouzes & Posner, 1995, p. 336). Leadership is the art of being oneself. “Neither science nor formula will produce a leader; leadership is a matter of character” (Bennis & Townsend, 1995, p. 13). Character is not reputation. Reputation is what others think you are. Character is who you really are. We don’t have to become someone else to become a leader, we have to be ourselves (O’Toole, 1995). In short, the leadership journey begins with self-knowledge.

To acquire self-knowledge, we must be acutely aware of how our life experiences have contributed to the development of our individual worldviews, the mental models of our reality. We must become cognizant of our own strengths and weaknesses, our values and beliefs. Since none of these factors is static, life is a work in progress. Leadership is the art of that progress: it is the art of becoming who we are.

“All great leaders have wrestled with their souls” (Kouzes & Posner, 1995, p. 339). The goal of this struggle is to get our egos out of our way. Once we do this we open ourselves to the strength and diversity of others. The fact is that leaders do not have all the answers. Indeed, “the true spirit of leadership is the spirit that is not sure it is always right” (O’Toole, 1995, p. 53). A leader must be able to admit their shortcomings, receive constructive feedback and make mistakes. True leaders value and seek differences of opinion by encouraging their constituents to critique their plans and ideas (Bennis & Townsend, 1995). Rather than believing he or she has all the answers, the effective leader is “someone who can assess a situation, bring people
together, build consensus, and discover solutions, drawing on the
talents of everyone involved” (Dreher, 1997, p. 5). So leadership
begins with the self, but it only works through others.

2. **Leadership listens.**

There is a strong consensus in much of the literature that
effective leaders are interpersonally competent (Kouzes & Posner,
1995). As a leader and a follower, I see the ability to
communicate effectively as one of the most fundamental factors
in interpersonal competence. Lack of communication creates
chaos and confusion and negates the development of a shared
vision. Open communication “builds integrity and nurtures trust”
(Dreher, 1997, p. 223). A leader should be authentic and
enthusiastic when communicating good news and “clear,
compassionate and concise” when communicating bad news
(Dreher, 1997, p. 172).

Effective communication involves more than clear speech. It
also requires skilled listening. “Listening is the yin and speaking is
the yang of effective communication” (Dreher, 1997, p. 162).
Listening to others makes people feel respected and is perhaps
one of the most powerful ways a leader can earn the trust of their
constituents. “It is also an invaluable way to learn about areas of
an organization [that are] usually unexplored and often
overlooked by a leader” (Bennis & Townsend, 1995, p. 174). So
listening is not only a part of interpersonal communication but
also contributes to a culture of learning. By listening we learn, but
we also earn. What we earn is the trust of others. This in turn
creates an openness to listen back. Listening is a two-way street.

While leaders require self-knowledge and interpersonal
competence, their primary goal must be to promote
organizational excellence. To reach this end, leaders must
become systems thinkers, lead change and promote innovation,
empower constituents to become self-leaders and develop
organizational cultures that support continuous lifelong learning.
Together these required activities make leaders into agents of
transformation. I will discuss each in turn.

3. **Leaders think in systems.**

“The teachings of Taoism and Buddhism, as well as the Native
American religions, affirm that we are all part of a larger whole”
(Dreher, 1997, p. 3). As leaders we must acknowledge this inter-
connectedness by becoming **systems thinkers**. Systems thinking
is a holistic approach to understanding organizations and the
interrelationships that make them up. A key feature of this
holistic approach is the development of a shared vision based on
the organization’s goals and mission. “A vision paints a picture of
what the organization must be if it is to survive” (Belasco &
Stayer, 1993, p. 91). As leaders, we must communicate this
vision in ways that are emotionally engaging, so that all
constituents become “stakeholders in the vision and its success”
(Bennis & Townsend 1995, p. 170). “Leaders speak to people’s
hearts and listen to their heartbeats because, in the final
analysis, shared visions are simply about common caring”

Systems thinking also requires the systematic evaluation of
the ways in which we think about our organizations. These ways
we think, these mind-sets, are our mental models (Senge, 1990).
They can be functional or dysfunctional. Leaders need to remove
the organizational obstacles that are rooted in our mental models
by engaging constituents in the process of dialogue and inquiry.
They can only do this by actively listening to what constituents
have to say and by “appreciating their particular viewpoints”

A third challenge of systems thinking is handling paradox,
those contradictory forces that are inherent to organizational life.
Paradox and contradiction are ineliminable from complex
organizations. They defy reason, but leaders can draw on their
intuition to deal with them. Systems thinkers use intuition to
balance organizational paradox. Balancing paradox can be “a
matter of possessing varying traits, of knowing when each is
needed and of bringing each to the fore when it is needed and
appropriate” (Bennis & Townsend, 1995, p. 167). But leadership
must also balance values, for example by creating “a culture with strong strategic unity while at the same time fostering sufficient internal openness to encourage freedom of action and entrepreneurial initiative” (O’Toole, 1995, p. 47). The intuitive art of balancing paradox is an invaluable systems thinking skill for leaders.

4. Leaders lead change.

“One of the most important and difficult leadership responsibilities is to guide and facilitate the process of making change in an organization” (Yukl, 1998, p. 459). To date, most of the planned organizational change I have experienced as a nurse has been imposed without dialogue. This has contributed to an angry, mistrustful and cynical workforce, and has created an organizational culture resistive to change. Based on my negative experience with poorly managed change, I concur with O’Toole’s argument for values-based leadership. Leadership is not about managing change, it’s about leading change. It requires us to practice the art of inclusion by meeting with constituents and to engage in active listening with them. If people are included in the change process, they feel respected, become energized and are far more likely to implement innovative changes that contribute to organizational success (O’Toole, 1995).

Having said this, in my view it is equally important that leaders not lose their perspective. O’Toole (1995) clearly articulates this point when he states “leadership requires listening to followers but not becoming prisoners to their low expectations” (p. 47). Change must be led in a way that transforms followers and cultivates innovation. When change is merely managed, followers and innovation are both suppressed. Therefore, the competent leader intuitively knows that “one can not manage change (one) can only be ahead of it” (Drucker, 1999, p. 73).

5. Leaders empower self-leaders.

As leaders, nurses have an obligation to create and encourage “the emergence of a new generation of leadership” (Bennis & Townsend, 1995, p. 176) by becoming role models and mentors to their constituents. They must engage in transformational leadership and share leadership with their constituents by “inspiring them to be more committed, building their self-confidence, and empowering them to take more initiative in carrying out their work” (Yukl, 1999, p. 328). As servants, leaders must be committed to improving the quality of the work life of their constituents by removing those obstacles that prevent great performance.

Today, as a result of the critical nursing shortage, nurses on the front lines are fighting an uphill battle. They are being forced to look after more acutely ill patients with far fewer human and financial resources. They are foregoing lunch breaks and giving up their days off to work overtime shifts, all in the name of patient care. They are becoming fatigued, disheartened and experiencing symptoms of burnout at an alarming rate. If this trend continues, fewer individuals will enter the nursing profession and those currently employed in the profession will continue to seek new and more satisfying careers outside nursing. There is no disputing that nurses are “too valuable to lose though neglect” (Bennis & Townsend, 1995, p. 184). It is therefore imperative that administrators and nursing leaders “combat and make provisions for burnout” (Bennis & Townsend, 1995, p. 184).

Within our current health care system, this is unfortunately not happening for nurses, although it needs to happen. It therefore becomes the task of nursing leaders to ensure that it does happen. First and foremost, front-line nursing staff need to become a stronger voice within the health care system. Transformational leadership provides one viable approach to providing nurses with the inspiration, vision and empowerment
they need to become recognized as a distinct discipline of self-leaders.

Next, nursing leaders must make greater efforts to nurture this overtaxed workforce by being committed to improving nurse’s quality of worklife. As a start, they could remove the fundamental organizational obstacle rooted in a mental model that says “nurses must be all things to all people.” Nurses have spread themselves too thin at the cost of neglecting their own physical and mental well-being. In short, nurses must be valued and respected as human beings who have needs of their own. Until this happens the profession of nursing will not be able to attract new and talented people.

6. Leaders cultivate learning cultures.

If leading is about learning, then maximizing everyone’s potential through continuous learning is essential to organizational success (Belasco & Stayer, 1993). “The key to success (and perhaps even survival) in the next century – for all of us, but for leaders especially – is the familiar expression ‘life-long learning’” (Kouzes & Posner, 1995, p. 334). As leaders, to be truly committed to developing self-leaders and organizational excellence, we must ensure organizational cultures that promote personal development and nurture lifelong education. “Learning ... is the sine qua non for both personal and organizational vitality” (Kouzes & Posner, 1995, p. 335).

7. Nurses and shared leadership.

So far I have discussed my own theoretical perspective (biases if you like) regarding leadership. I would like now to look at an example from my own experience to see what lessons can be learned.

A number of years ago while working as a nursing leader, the hospital where I worked became the target of a corporate takeover. Associated with the takeover was the development of a new corporate name, symbols, colors, right down to the letterhead – all at a substantial cost to taxpayers. Shortly thereafter, in an effort to revitalize the newly formed organization and merge the two very distinct cultures, the organization implemented an American model of health care delivery known as Patient-Centered Care. In essence the Patient-Centered Care model supports the principle that, regardless of professional, financial or organizational constraints, health care providers must acknowledge, value and respect the patient’s perspective. As the name implies, the patient’s needs are the absolute goal of health care delivery in this model.

The new vision seriously impacted all health care providers. However it had the most profound impact on registered nurses, the largest group of health care providers. After all, it is nurses who meet the needs of patients and families 24 hours a day, 365 days of the year. It is nurses who respond to the many requests and in some cases unrealistic demands of patients and their families.

The model of Patient-Centered Care was not without its advantages. It did provide a mechanism for articulating to patients, employees and funding sources a vision that was “simple enough to be understood, appealing enough to evoke commitment and credible enough to be accepted as realistic and attainable” (Yukl, 1998, p. 338). The model also assisted top-executives and middle managers in developing “a sense of purpose about their membership in the organization” (Yukl, 1998, p. 336).

In spite of these advantages, the Patient-Centered Care model has some serious flaws, particularly for those caregivers most impacted by the model. While the essence of nursing is about caring for patients, if this is done at the expense of the caregivers, little will be gained in the long run. Given the current nursing shortage we must ask about the cost of narrowly patient-centered models. Ultimately, the quality of patient care and the quality of worklife for nurses are not mutually exclusive; in fact, I
would argue that they are interdependent and inextricably related.

With this in mind, the one-sided nature of the Patient-Centered Care model is clearly visible. Herein lies the fundamental weakness of the model. As a workforce, nurses today are overburdened. If nurses are not themselves acknowledged, valued and respected, they will simply not have the mental, physical and emotional stamina to provide quality care. This is no road to empowerment, and it will not lead to the retention of nurses in the field. Therefore the task of health care administrators and nursing leaders of our day is two-fold: first, to openly acknowledge the inherent stressors associated with being a nurse in the 21st century; and second, to collectively develop and implement innovative solutions to solve these complex problems.

While concrete solutions need to be collectively developed, some guidance is suggested by my earlier theoretical considerations. Nurses need to examine themselves and take leadership to address the problems confronting them. They cannot wait for others to do so. But nurses are not alone in the health care system. By engaging in dialogue and inquiry with nurses, upper executives who are not themselves nurses can become more educated about the needs of nurses and about nursing as a unique health care discipline. Once enlightened, upper executives can become a stronger voice for nurses and can assist nursing leaders in the removal of organizational obstacles rooted in antiquated mental models.

As servants to their constituents, nursing leaders must also make a concerted effort to educate other health care disciplines, not only about the distinct role of nurses, but about what those disciplines can reasonably expect from the nursing profession. Similarly, by actively listening to what frontline nurses have to say about the conditions of their work, nursing leaders will better equip themselves to identify and eliminate the organizational factors that harm worklife quality and negatively influence performance.

Today, change is a reality of organizational life. To be effective, nursing leaders must move beyond managing change: they must practice the art of inclusion by involving all nurses in the change processes that directly affect their work. And they must tap into the talent and expertise of front-line nursing staff to discover innovative and creative strategies for leading change and promoting innovation.

Leaders must encourage the development of a new generation of leaders by empowering nurses to become self-leaders. Further to this, administrators and nursing leaders alike must see to it that this new generation of self-leaders is equipped to provide state-of-the-art nursing care using evidence-based practices. To reach this end, leaders must see that nurses have the time and energy to pursue lifelong learning. And finally, by developing organizational goals that balance the commitment to quality of care for patients with the commitment to quality of worklife for care providers, leaders can develop a shared vision that addresses the needs of all stakeholders.

In conclusion, “the new leader is a facilitator, a communicator, a team builder, who realizes that our greatest natural resources are our minds and hearts, together with those of the people around us” (Dreher, 1997. p. 5). As we begin the 21st century, “changes in technology, demographic diversity, and globalization will require our leaders to be more articulate, energetic, and empowering than ever before” (Bennis & Townsend, 1995, p. 11). As leaders we must pursue our journey by sharing leadership and engaging in lifelong learning in order that we may collectively create the new ideas and innovative strategies that will benefit us all in the future.
Note: I would like to thank Michael Picard, Ph.D. for his support and inspiration in helping me write this essay. His editorial suggestions were so extensive that he might well be considered a joint author of the final result; however he has declined on the grounds that the paper in fact expresses my personal beliefs and experience concerning leadership in the health care system.

Janet Hoffman

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Leadership: More Than the Sum of Our Senses

Leadership is complex, dynamic and not easily defined. In truth, defining leadership is like trying to write a description of a cloud, the form and function of which changes before the ink has dried on the page. To view leadership as nothing but a compilation of skills and attributes, an objective exercise, is to miss an opportunity for a marvellous adventure, a conscious encounter with the universal energies and dilemmas of the human experience. To my way of thinking, leadership is an art form, not a science. A way of seeing. The art of arranging things to answer an intended purpose. A way of hearing. The art of not only listening, but also hearing one's self and the world. A way of touching. The art of being connected to one another. A way of smelling. The art of sensing change and opportunity. A way of tasting. The art of experiencing life. Sharpening the saw of our five senses and recognizing the interrelatedness of one to the other has a synergistic effect. Leadership becomes more than the sum of its parts.

Leadership as a way of Seeing:

I believe that the capacity to see not only what is happening today, but also envisioning what can be, what must be in the future, is an integral component of leadership. Visioning has been a cornerstone of leadership theory from Biblical times. “Without vision, the people perish” (Proverbs, 29:18). Lao Tzu also reminds us to “Be aware of small things and develop great wisdom” (Tao te Ching, Ch. 52). This awareness requires systems thinking and a deep understanding of the forces that must be mastered to move from here to there (Senge, 1990, p. 12). Leaders have both a detailed focus on day-to-day activities, as demanded by contingency theorists, and a futuristic down-the-
road view. As a leader, you must help the people around you to face both today’s and tomorrow’s realities. The leader must have the courage and commitment to partner with people, see the problems, envision future possibilities and work toward a common goal.

**Leadership as a way of Hearing:**

The art of listening to self and others is essential for effective leaders. Listening involves looking inward, understanding your will, your mind and your heart. Tapping the reservoir of the potential that lies buried and often unattended is advice with roots in Taoist philosophy. “The wise leader, encourages open minds and strong centers” (Tao te Ching, Ch. 3). Being a leader is as much about your own self-development as it is about coaching others in their personal growth. Both demand a deep listening to oneself, which has always been the foundation of personal mastery.

Such personal mastery is more than the development of competence and skill. It is the becoming aware of our spirituality and therefore of our essential creativeness, which is at the core of personal mastery. “Creating is knowing the “inner” experience of that which we make, as well as the “outer” form it embodies. In other words, when we create, we convey spirit” (Hill, 1998, p. 2). Listening starts within, but is a movement from the inside out, from ourselves to the service of others. Inner hearing makes outer harmony possible.

Listening also involves facilitated dialogue or mutual inquiry between individuals in the quest for true understanding of each other’s reality (Senge, 1990; Short, 1998). Active listening as a communication tool involves a commitment to openness, honesty, and humility. Proponents of realism or charismatic leadership use communication as a means to an end. I, however, agree with Covey (1989), who states that empathetic communication of information builds synergy and achieves of high levels of trust and cooperation among individuals. Leading through hearing becomes an ongoing process of discovery of self and others.

**Leadership as a way of Touching:**

An important component of leadership is the ability to connect with others. This connection is dynamic and mutual. The connection is neither based on right, as it was for Plato’s Philosopher King; nor on might, as outlined by Machiavelli; nor is it a result of certain charismatic attributes. Leaders of today establish tendrils of connection between people by holding firm the belief that every individual has intrinsic worth. The leader reaches out and touches others by believing in them. Leaders honour people and trust people; they encourage diversity and involvement. (Hegleson, 1995). We connect with others through the process of finding meaning (Senge, 1990), through the creation of a clear and coherent identity, by allowing information to be the medium and not the currency of our organization; and most importantly by entering into meaningful relationships with others (Wheatley, 1996). The leader’s role in relationship has developed from one of control, as conceived in contingency theory, to one of service, as outlined by Peter Block (1993) in his book on *Stewardship*. The effective leader can no longer be the parent of individuals but must establish a partner relationship, one in which commitment, responsibility and accountability are shared. This is touching others at its best. As De Pree states, “at the core of becoming a leader is the need always to connect one’s voice and one’s touch” (1992, p. 3).

**Leadership as a way of Tasting:**

Metaphorically speaking, taste can be defined as having an appreciation for something. “It is known that the Taste (whatever it is) is improved exactly as we improve our judgment, by extending our knowledge, by a steady attention to our object, and by frequent exercise” (Burke, 1759).

Leaders must extend their taste for experience, they must demonstrate a zest for life, learning and leadering. They must
have an insatiable curiosity that seeks new horizons and ventures down new paths. T. S. Eliot writes, “We must not cease from exploration.” We have come a long way from the “realist” assumptions that subordinates were simple and unimaginative with limited potential for creative thought or innovative action. We have come to appreciate that all individuals strive to find meaning and joy in their life’s work. As leaders we must foster and cultivate this taste for novelty and innovation. Role modeling, coaching, sharing information and providing choices are essential leadership tools which can empower individuals to extend themselves in life. As John F. Kennedy stated in his 1960 inaugural speech, “Ask not what your country can do for you, but what you can do for your country.” People are attracted to and influenced by genuine enthusiasm; they feed on it. They soon become energized, stretching themselves beyond the boundaries of their safe and comfortable world.

**Leadership as a way of Smelling:**

Leaders must have a well-developed sense of smell, much as animals use this sense to define social territories, protect themselves, communicate and interact with the world. Leaders must be able to sniff out the culture of an organization, recognize the shifting winds and underlying currents of change, and anticipate the future. They need a nose for values.

As risk takers, leaders lead with a keen sense of the prevailing winds. Machiavelli (*The Prince*, Ch. 25), who states “he will be successful who directs his actions according to the spirit of the times,” supports this. Many leadership theorists, from as far back as Lao Tzu, knew that leaders must have a sense of the right time to act, to pause, to reach out and to reach within. If something in the environment changes, leaders must take notice and discern whether it might mean danger - or opportunity. Leaders must have the capability to size up and seize the moment. They must smell opportunity.

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**Beyond the Senses:**

Leaders rely on their senses, but the input garnered from these adds up to much more. As systems theorists note, the whole is always greater than the sum of its parts. There is heart, soul and spirit to leadership. Leaders not only rely on the input, perceptions and interpretations of information from the five senses, but they also have an awareness that goes beyond the conscious intellect. True leaders recognize and acknowledge that intuition, or the sixth sense, is the gift that allows a leader to do the right thing. This intuitive knowing begins by journeying inside, releasing yourself from the control of the psyche and personality while listening to the inner resources of your soul. Human logic, sharpened by the input of the five senses, must be in harmony with the heart and soul of the leader. This is the art of leadership.

**Reflections on Nursing Leadership:**

“It is something to be able to paint a picture, or to carve a statue, and so to make a few objects beautiful. But it is far more glorious to carve and paint the atmosphere in which we work, to effect the quality of the day - This is the highest of the arts.”

Henry David Thoreau.

How do we as nursing leaders practice the art of leadership on a day-to-day basis? Stewart (1929) states that the very essence of nursing lies in the creative imagination, the sensitive spirit and intelligent understanding. This is the foundation for nurses and nursing leaders. Nursing is more than technique and so to is nursing leadership. The artistry is attained through a deep respect and commitment to the science of nursing (or the head), the spirit of nursing (or the heart) and the skill of nursing (or the hand). Nursing leaders must understand the importance of seeing not only the present but the future as well, and they must paint that future for others so that nurses will continue to thrive. They must listen to self and others with their hearts and their heads. Nursing leaders demonstrate caring for others through
involvement, respect and trust. They encourage new ways of thinking, being and doing, thereby enhancing the head and hand of nurses they are entrusted with. By keeping an eye on the future and a foot in the past, nurse leaders remain rooted in the essence of nursing as envisioned by Florence Nightingale. Florence Nightingale pursued a mission of service to humanity throughout her lifetime. Nursing leaders must also dedicate themselves to service. Service to others through skillful leading. This can only be achieved by awareness, veracity, tenaciously, diligence, courage and commitment. As with nursing, leadership involves a type of perception that is active, dynamic and developing. An emotional quality guides the transformation of the material in art. Art is thus a form of qualitative inquiry that draws its substance from the esthetic insight. Technique, soul, mind and imagination are all essential components of the art of leadership.

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As I began writing this paper, I thought, "These papers are a hard act to follow." It then occurred to me how appropriate that response was. For in articulating to me — and you — about what leadership in health care means to nurses, the authors have exercised a key element of leadership itself: giving voice to themselves and the concerns of their peers. I learned from them.

Each of the contributors to this volume provides us with a unique and individual perspective on leadership in health care. To synthesize their views into a singular concept of leadership we chose the term Caring Leadership.

Kim Dougherty introduces this theme in the title of the first paper of this volume: "Caring Leadership: A Journey back to Kansas." What I hope to do is to take us forward from there — to Canada — and provide you with a view of the elements that working nurses consider to be essential for Caring Leadership to take form and life.

I. Leadership, Health and Care

The first step in taking us forward is to examine the true significance of the words, "leadership", "health" and "care", beyond their traditional uses. I recently noticed that I was using these words as a mindless mantra, without beginning to understand what they really mean. And I discovered others, not simply describing the delivery of medical services to others, but talking about the Canadian health care system as if we all knew what these terms really meant. Yet each of these terms conceals deep philosophical assumptions and evokes strong emotive responses. That is clear in the contributions to this book. Each author delves into the concepts of leadership and care in the unique domain of health services, a territory I wanted to explore with them. So in the first part I look at the various meanings of these terms.
In the second section, with direct reference to our contributors, I outline the Seven "C's" of Caring Leadership — seven aspects of what leaders in health care must feel, do, or contemplate — in order to do Caring Leadership well. Finally, in summation, I will share my hopes with you in the form of three key leadership activities that I feel must be undertaken if the Canadian health care system is to meet the challenges of the future.

**a) Defining Health**

A dictionary definition of health might run as follows: a state of being hale or sound in body, mind and soul. Metaphorically represented on a heart monitor, health expresses itself in peaks and valleys, various states of being as represented by the relative soundness of mind, body or soul. Death, on the other hand, is the monochrome condition of a flat line. One terrain is not comparable to the other, nor can each be bartered with the other as if they were commodities of equal value.

The true challenge of health leadership is not simply to avoid death, but to enhance the quality of life. But oftentimes administrators — those charged with the formal responsibility for leadership — equate survival of the body with health. Thus we pursue health reform in which "technical" treatment of patients, through enhanced efficiencies, takes precedence over our ability to enhance the quality of life of patients, or of our care providers (Noelle Andrews). There can be a tendency to become administrators who revere technocracy, rather than those who enable the heart (Sharon Faulds) or enhance the soul (Janet Hoffman). And worse, nurses can be drawn into a mindset of martyrdom in which their own health is neglected (Margaret Gauthier). Worst of all, we can all lose the very essence of nursing: its sensitive spirit and its intelligent understanding (Johanna Montigny).

Nurturing of the soul — individual and corporate — is foundational to leading health care into the future. "The body needs rest, and it needs care, but behind every aspect or illness of the body is the energy of the soul" (Zukav, 1989, p. 189). The soul is the essence of the human spirit — that element that defines our commitment to life, and to each other. Yet the soul is often the most neglected aspect of our health care system. We invest money in education to train the mind, spend immense dollars to improve medical technique for the body, but expend little to nurture the soul. And health — by definition — requires that a balance be maintained between mind, body, and soul. By extension, this requires that leaders in health care invest much more into their own soulness; and find ways to stimulate soul within the system they steward.

**b) Defining Care**

In the movie *Critical Care*, Dr. Ernst (portrayed by James Spader) makes an impassioned plea to a roomful of health care professionals to remember the patient in bed 5: to make decisions with care for the patient in the forefront of their minds. Few of us would disagree with him. Care is a foundational concept for health professionals.

In the movie, the dilemma was simple. Everyone in the context of this specific patient understood the meaning of the word "care". It meant exercising the charge, custody, or responsibility a doctor or nurse has for a critically ill patient; expressing concern and interest in the patient's welfare; and paying close attention and exercising solicitude for someone in harm or danger.

In this context the theme of the movie was that many people who understood the meaning of "care" and were supposed to care have difficulty actually practicing it, rather than pursuing their own personal interests. And the message was clear: too many of us in "health care" lose sight of the patient.

This is an important message. But only the most obvious one. For there is another dimension to the word "care." It can also denote a burdened state of mind, as that arising from heavy responsibilities, worry, mental suffering or grief. Kim Dougherty,
in her paper, talks about this theme as "over-caring" by nurses, which leads them "into co-dependence and burn-out". Too much caring for others can lead to not enough caring for oneself. And just as balance is required in health, balance is also required in care. This is particularly important when one is encouraged to exercise "servant leadership" — that is, to put service to others as the fundamental purpose of leadership (Stephanie Buckingham).

So one is required, in the helping professions, to balance care in the positive sense, with care in its negative sense. Indeed, the ability to manage this paradox is one of the essential struggles of leadership — a struggle that is at once deeply personal and philosophical. Noted psychologist Lawrence Kohlberg, for example, suggests that the highest state of ethical awareness is to adjust our thinking and feelings so as to ensure that the fulfillment gained through service exceeds the amount of unhappiness occasioned through fulfillment of one's caring responsibilities.

Carol Gilligan (1982) goes even further. She suggests that the true challenge here is to "remove the conditions that create the dilemma," not resolve it as if it were a technical problem. She argues — as do many authors in this volume (Kim Dougherty; Linda Byrnes; Sharon Faulds) — that administrators should employ participatory decision making approaches, engage in dialogue, listen, and develop strategies to create a shared vision as leadership strategies. In this sense they are suggesting that the "caring paradox" can be eliminated. In essence they are saying that if respect (rather than need) becomes the basis of human interaction a more fundamental state of caring exists.

"Care," in yet another sense of its meaning, suggests caution: avoidance of danger. Emphasis on caring in this sense can create another paradox to be managed by those leading. For leadership requires risk-taking (Margaret Gauthier). Yet if one defensively interprets "care" to mean excess caution, it is easy to slide into resisting all change, as potentially "too risky". Fear of change can lead us to be over-cautious, and this to caring less than we can.

Another key concept involved in the meaning of the word "care" is responsibility. In the Critical Care movie example provided earlier, it was easy to define care in the context of the patient-health/care-provider relationship: for someone who is sick, or desperately ill, needs care. They cannot take responsibility for themselves; they are in a state of dependence. And how seductive this can be. Health care providers can get very comfortable taking responsibility for people who are not able to be responsible for themselves. When one is healthy in the physical, mental, or soulful sense (that is, when one is able to care for oneself), one is deemed responsible. So where does care fit into this context? Is it captured by the concept of treatment, or does it expand to include health prevention and health promotion? And how does one who is used to caring for people in a dependent state adjust his/her strategies of care for people in an independent state? Is this a particularly difficult transition for care-givers, who are used to working with patients, to make when they move into administrative roles and are asked to "lead" healthy individuals in the organization? Many authors in this volume suggest that it is a difficult transition. Noelle Andrew, for example, cites numerous examples of undesirable leadership behaviors that resulted from the individual's inability to recognize the responsibility of others. Lynda Byrnes' "learning organization" model is predicated on the exercise of personal responsibility. Johanna Montigny's concept of personal mastery manifests the ideal of personal responsibility.

Inherent in the concept of caring are many different perspectives on leadership. At the core and foundation, however, is compassion and empathy for others. How this manifests itself strategically should be determined by the various needs people are experiencing, and the different degree of responsibility that exist amongst the individuals that provide and receive health care. And certainly one of the greatest challenges to those who take on the mantle of leadership is to retain a personal perspective and emotional maturity that enables them to deal
with, or re-conceptualize, the inevitable burden that caring entails.

c) Defining Leadership

In her article entitled "What does leadership look like in the hearts and minds of nurses?" Stephanie Buckingham points out that in the literature, there are at least 650 definitions of the concept of leadership. In addition, each of the contributors to this book adds her own views of what leadership means to her. Based on their input, I choose to define leadership in the context of this paper as:

The ability to influence others to act responsibly together in the pursuit of quality health for themselves and for the citizens of Canada.

In this sense I am defining leadership as a combination of what some other authors may differentiate as three separate functions: leadership, administration, and management. I am doing so because leadership in the narrow or more specific sense — the ability to bring into being new ways of thinking, to seek out new directions, create innovative ways of doing business — accomplishes nothing if the administrative and management supports are not built to sustain those new directions.

Leadership in the broader sense implies that everyone in health care is a potential leader. As many contributors note, leadership is not simply a responsibility of just those in positions of administrative authority. Anyone who understands the need for new directions; who cares for others; who understands that health exists in a balance of concern for mind, body and soul; and who has a responsibility in building the supports for these concerns, is charged with the responsibility for leading. And anyone is called on to exercise leadership when practices are being undertaken that are antithetical to these principles.

II. The Seven C's of Caring Leadership

Caring Leadership brings together the concepts of health, leadership and care to create a unique perspective on how to conduct leadership in the health care system. Building on the contributions of the authors in this book, I have identified the The Seven C's of Caring Leadership. These are:

![Diagram](image)

Each will be explained in more detail with reference to the various authors and my own experience. It is important to note that each of the seven C's can be construed as aspects of personal style and ability; or they can be understood as elements that permeate an effective team, organization or system. As a consequence, one who aspires to leadership must accomplish three things. The first is to seek out ways and means to stimulate these qualities internally and have them manifest in his/her personal behaviour. The second is to know how to how these concepts play out in team, organization and system contexts. The
third is to acquire and implement the skills and abilities required to operationalize the seven C’s.

i) Compassion

It was stated earlier that compassion lies at the core of caring. Compassion is a quality that combines empathy and sympathy— the compound ability to put oneself in another’s shoes and to share common feelings or concerns. Compassion has the added quality of wishing to assist, to alleviate, in the case of unpleasantness, the suffering of others.

Compassion is the prime focus of the gardener metaphor that Sharon Faulds uses to define leadership in her paper, “The Leader/the Gardener.” From the personal perspective, the source of energy to sustain compassion is love: “When you are in love with the people you lead...you pour your heart into it.”

Compassion flows from the degree to which one’s own soul’s calling—that is, the essential life force that resides within us—is commensurate with the calling of others. Compassion is also a function of our individual ability to call it into force: we do not each have a finite quantity of compassion to expend. Compassion is stimulated into being and can be grown through awareness, deliberate action and shared experience with others.

Compassion for individuals who are sick or ill draws many practitioners to health care. One is first drawn to express sympathy for the ills of the body or mind, and then to take measures to alleviate those concerns. However, when individuals then make the transition from patient care to administration, the focus of compassion needs to change. It shifts from concern for the body and mind to concern for the soul. Compassion in this instance means being sympathetic to the needs of people to feel respected as equals, to be trusted, to be recognized for their unique talents. Compassion enables them to exercise the leadership that they are capable of in the role they possess. As Sharon Faulds states, “in the end, the garden deserves the credit for its beauty.”

Kim Dougherty, in her paper, “Caring leadership: A journey back to Kansas,” outlines the power of compassion amongst nurses themselves. She introduces the idea of Practice Circles®. In these meetings nursing colleagues shared ‘memories of caring and non-caring among nurses...they experienced the power of story-telling to illuminate their experiences for shared reflections, and to allow them to image their desired future.” She describes nurses “who went the distance with you, who noticed your pain, who called you at home and said ‘if you need someone to talk to I’m here.’ They recognized how amazing the bond between nurses was”.

Over-commitment to compassion also has a downside, what Barry Oshry (1995) calls becoming a “burdened top.” In his view, individuals who assume leadership responsibilities are prone to lose the balance between responsible caring and dependent caring. Kim Dougherty suggests the potential for this when she states that “...caring leadership was nurse’s expertise. It was what made others fear them and their power. It was also what made nurses fear themselves.” In this instance a pattern becomes established in which the leader distances herself from the group, and assumes their responsibilities for leadership. Often enough the group lets her. This dynamic can also happen in an organization when a group becomes self-referential, or creates dysfunctional closed behavioural groups (Linda Byrnes). Practice Circles® can help nurses, but if not managed properly, can also separate nurses from other health care practitioners.

Ultimately, the quality of compassion — to be the force for leadership that it must be — is one of the most difficult for individuals to manage. The key to managing it is the second “C” —Character.

ii) Character.

Character is the capacity of an individual to ensure that his or her actions reflect the timeless qualities that are admired in whomever possesses them. Qualities such as honesty, integrity, courage, duty and determination have been revered for
thousands of years. An old Chinese proverb suggests, for example, that a leader is someone who falls down seven times and gets up eight. Dreher, quoted in Sharon Faulds' article, states "Leadership with the Tao is above all else a matter of character. It is transcending ego, looking beyond ourselves to find the lessons all around us". And as Stephanie Buckingham found in her research, "Public health nurses view honesty, integrity...as integral components of leadership". She goes on to state that they admire leaders in their midst "who stand up for what they believe in.

Individual leaders find their character tested every day in health care reform. Determination is tested through the sheer volume of circumstances in which they are asked to embrace a policy or proposed action that is "unrealistic, inefficient, and top-down, based on old models and new management fads" (Noelle Andrews). It requires great strength of character to persevere in doing the right thing, to object to new directions, or to propose alternative forms of change, when one's beliefs and values are assaulted. It also requires significant courage to speak up against formal authority, particularly when to do so is viewed by that same authority as being obstructionist, or exerting mindless resistance to change.

Character is also the key to managing the inward stresses created by one's commitment to compassion and health. Honesty with oneself regarding the emotions one is feeling or one's true motives is demanded of anyone who wishes to truly understand self and feel compassion for others. Goleman (1995) indicates that emotional intelligence — the ability to be aware of and control our emotions — is required of anyone who wishes to be successful in leadership. Self-confidence, internal locus of control, emotional maturity, integrity, and gratification of self through satisfaction of others — these are other dimensions of character required to care as leaders must care, namely with respect for the needs and responsibilities of others (Margaret Gauthier). Finding the strength to continue to develop these capacities, rather than simply succumb to one's natural emotional state, is challenging to say the least.

Character is a basic to the ability of the leader to engage in meaningful dialogue with others in the pursuit of a shared vision. Deep knowledge of self — of what values are unshakably foundational to one's makeup as a person — is required before one engages in shaping joint purpose with others. As Linda Byrnes states, "The leader...has a purpose story that is both personal and collective...the leader must be able to tell and to demonstrate their own purpose story". And character is also required to maintain that purpose story when one is asked to change it to accommodate the visions of others. Knowing what one can give up, versus what one must maintain, is a fundamental test of character. After all, commitment to a shared vision is not a commitment to relativity: it is a commitment to being open to allow people to live their personal aspirations and beliefs, without having to compromise one's own.

**iii) Connections**

Character is the basis of a responsible, independent person. It is also required in order to operationalize the third of the key characteristics of caring leadership: Connections.

Two kinds of connections are pertinent to the concept of caring leadership. One is personal, the other systemic. The personal form of connections consists in relationships between individuals. Relationships in this sense are key to effective leadership. "Relationships are the essence of the living world..." (Capra, in Linda Byrnes). Healthy relationships personify responsible caring. Caring relationships are built on mutual respect, trust and shared responsibility. I am talking about relationships in which individuals get to know each other as people, not as positions; and in which each person's unique talents, aspirations and fears are mutually understood. When relationships of this kind exist, the potential for compassion and character to shape decisions system-wide is enhanced.

This leads us to a second key component of connections, feedback across organizational boundaries for learning. This is outlined in the paper by Linda Byrnes. She emphasizes how
important it is for leaders to think of the health care system as one holistic entity. Such a system is not simply a composite of the numerous individuals, teams and organizations and subgroups that comprise it. Rather, it is an independent whole that has an identity of its own. No part has an independent purpose, only a dependent one. But the client or customer doesn't see the independence of units that the provider sees. It is therefore important for each provider group to reach out to create connections with other components of the system. These connections create the opportunity to receive feedback on how well each is achieving its purpose in the overall context of patient care. It is through feedback on performance that learning occurs. When individuals or sub-groups in systems fail to learn, the system itself is prone to collapse. For example (as both Kim Dougherty and Linda Byrnes indicate can happen) nurses can identify themselves self-referentially as so unique that they refuse to receive feedback on their performance in the context of the whole system. Dysfunction in patient care will result. Certainly the ability of nurses to provide a seamless, coordinated continuum of care would be severely compromised.

iv) Creativity

In his introduction, Michael Picard outlines the many forces and trends that are creating the need for change in health care. The ability to be creative — to find and implement innovative ways of service delivery — is fundamental to the concept of caring leadership. Many of the contributors have emphasized how important creativity is to the leader. Margaret Gauthier for example states that leaders must be willing to look at things with a new lens rather than rely on the conventional attitude that prefers the way "the way we've always done things around here". Sharon Faulds reminds us that nothing remains the same, that "Nature tells us that everything will grow and develop". Noelle Andrews states that leadership is responsible for guiding and facilitating the process of change. And Janet Hoffman reminds us that the 21st Century will bring such changes in technology, demographic diversity, and globalization that the leader will be required to continually learn innovate.

Creativity may well be the essence of leadership. Leadership seek out new directions; administration determines how to build and sustain those directions; and management maintain what has been built. This element of caring leadership requires that the leader is aware of and can respond to trends in the environment as they emerge. Implicit in the concept of creativity is bringing into being new ways of seeing the world, new approaches to doing business, new ways of acting. At its core is the idea of doing something for the first time. This means that no model exists; there is no template currently in place to rely upon. One cannot go to existing practice for guidance. To design and accept truly innovative approaches to health care demands of leaders inspiration, intuition and confidence.

Inspiration means coming up with an idea when one is needed. John Kao, in his book Jamming, describes how an engineer at Sony corporation who was working on creating the first mini-tape machine had puzzled for months over how to get speakers into the small box that defined its size. And suddenly — in a moment of complete inspiration — he thought of the idea of headphones. And the Sony Walkman was born. To stimulate inspiration, people need time to reflect; they need an opportunity to be free of the traditional surroundings; and sometimes they need to be challenged to think in new and innovative ways. For example, Roger von Oeck's Whack Pack is a tool that leaders can use to stimulate inspiration.

Confidence is another key requirement of creativity. Creators are constantly challenging the status quo. As a consequence they often incur scepticism or irritation because they are slowing things down; asking unproductive questions, or simply thinking in a different space from others. Meredith Belbin (1980), an English researcher, has noted that the most creative people on teams are often the most marginalized or discriminated against. A good example of this marginalization can be found in the movie
Contact. Elly Ereway, the Jodie Foster character, is seen presenting her vision to a foundation board, in order to gain funding for her project. They evince scepticism, indeed, dismissal. In a pique of anger, she challenges them to think in terms required to realize the project, "to have just a little vision." In doing so she demonstrates the inevitable frustration that creators feel when they have a vision of the future that no one else can relate to. To be creative on a personal level, one must have the fortitude to persevere in spite of criticism. To stimulate creativity in others, the leader must provide the environment and the tools, as well as be encouraging what might well appear to be extraneous thinking.

To have a vision and to engage others in sharing it is a creative leadership ability. Johanna Montigny states, for example, that leaders need the capacity to "see not only what is happening today, but also envisioning what can be, what must be in the future." The centrality of vision as a motivating force is also a constant theme in other papers. A vision creates motivation and hope; and, if it is created in a participatory fashion, it "enables people to thrive, grow and fulfill their dreams in the workplace" (Sharon Faulds). A shared vision stimulates a willingness to change. Margaret Wheatley (1994) confirms this when she states: "People support what they help create". However, the key here is the requirement for that vision to be developed together. Janet Hoffman's paper suggests that this is not necessarily the norm in health care: she states that "most of the planned organizational change I have experienced as a nurse has been imposed without dialogue." To be a caring leader, it is fundamentally important to ensure that the organization's vision fully embraces the concept of caring; and that means caring not just for patients or clients, but also for the care-givers, by giving them voice, influence and the space to create their own future.

v) Commitment

Commitment is required of the caring leader. Commitment means having the will and determination to stay the course, to pursue a goal and to develop the skills and abilities required to achieve it. Commitment is a pledge to do what it takes to accomplish what is important.

Commitment springs from the will. Will is a force that binds people to ends beyond their means, beyond their times. The source of sustained will is one's deepest values and beliefs, supported by the character to pursue them. It is a quality of leadership captured by Sharon Faulds quoting Dreher, who states: "It means living our lives to make a difference, inspired by the strength and resilience of nature."

A shared vision — described earlier — stimulates commitment. Commitment is enhanced if one can build the shared vision through sharing one's own "purpose story" (Linda Byrnes), and when individuals are able to express and promote the values that are important to them (Stephanie Buckingham). A good example of how a shared vision can stimulate commitment is found in Bev Dobbyn's paper entitled, "Caring: Who takes a leadership role?". She describes how the nurses on the unit she studied initiated a process of creating a vision for themselves, indicating that it was a difficult process requiring time and energy. She quotes a nurse who saw the power of purpose in creating commitment, and who said, "we need an identity...we have control over."

The concept of servant leadership, addressed especially by Stephanie Buckingham, represents the commitment to compassion that is at the essence of caring leadership. She quotes Spears on servant leadership, "At its core, servant leadership is a long term, transformational approach to life and work, in essence, a way of being that has the potential to create positive change throughout society." One of the nurses in Bev Dobbyn's study expresses her commitment to servant leadership in this way: "...we do an awful lot, and...want to do it. And I think that everybody really has those patients' best interests at heart."
Cooperation/collaboration

Cooperation and collaboration are fundamental aspects of caring leadership. Linda Byrnes emphasizes the importance of cooperation/collaboration when she says, "The concept of everyone being part of the problem, of the blame not being one person’s or one department’s, is integral toward working toward positive behaviours within the health care system." Johanna Montigny uses the sensory metaphor of leadership as touch to signify the importance of cooperation. Sharon Faulds emphasizes collaboration when she states that an important dimension of leadership is the ability to "encourage, support and guide" others. (In fact, Goleman (2000) identifies this ability, which he calls coaching, as one of four fundamentally important leadership styles.) Noelle Andrews emphasizes the fundamental importance of cooperation and collaboration to health reform when she states that "Nurses need the chance to come together to examine what is working, what is not, and what can be done more effectively." And Kim Dougherty is of the view that the real essence of nursing leadership is the "amazing bond" between nurses.

Cooperation and collaboration is a result of the link between two other C’s of caring leadership: compassion and connections. Being able to cooperate or collaborate with others is a fundamental ability required of individuals who wish to achieve a common purpose. Cooperation means the ability to work well with another individual or collectively with others within one’s own work group in pursuit of a common benefit or purpose. It requires two skills: first, the ability to find a common interest with someone else; and second, the ability to work with that person in pursuit of the common interest.

Collaboration extends the idea of cooperation into the world of organizations and systems. Collaboration is not as permanent as cooperation. Groups or agencies can collaborate on specific projects, and then not work together again. Collaboration can be required between working groups in one’s organization (i.e., cooperation between acute and community care), between programs in a health region (i.e., frail elderly and mental health), or between organizations in the community (between the health region and the municipality, for example). Collaboration often means working with other groups or agencies that one does not normally work with. It sometimes implies creating partnerships with competitors or agencies that are not in one’s direct sphere of influence on a daily basis.

Nurses who aspire to lead primarily in client care will need to exercise cooperation with peers, their direct supervisor, and with clients that they directly contact. Supervisors of nurses need to provide nurses with the opportunity to get together and share stories, investigate what their common purpose is, and to plan to achieve it. Work units need to collaborate with other work units in order to ensure that the client has seamless care, and that inefficiencies of operation are eliminated. Bev Dobbyn, in her study of a transition care unit, discovered that creating common identity helped nurses cooperate, and creating formal connections and dialogue with outside working groups to collaborate on patient care, were key to improving morale and productivity within that program. In a similar fashion, union and management need to find that “common identity” for which they are both working, and to develop participatory practices and processes for decision making, implementation of change, and resolution of differences. Cooperation and collaboration need to be essential principles underlying leadership behaviours.

vii) Competence

One cannot lead if one’s intentions are not reflected in one’s behaviour. Statements like “Leadership listens” or “the new leader is a facilitator, a communicator, a team builder” (Janet Hoffman) recognize that certain behaviours create the capacity to lead. Stephanie Buckingham states that a leader will have strong communication and interpersonal skills, political savvy, be a strong team member and collaborator, and be possessed of a good sense of humour. The ability to run meetings, to conduct
sessions to create a shared vision for the organization, and to develop processes and policies that engage others in decision making, are all important manifestations of the intent to care for others. And, of course, at the core of any profession is the ability to exhibit the unique craft of that profession in one’s interaction with one’s clients.

Competencies are a combination of knowledge, skills and attitudes that result in effective and quality behaviour. These competencies create behaviours that are the evidence upon which we decide whether or not someone else can lead — and whether or not we will follow. The intent to care for another, or to exercise leadership so that the health care system cares for its employees and for citizens, has no currency if it is not reflected in behaviours that demonstrate care.

For example, what are some of the personal, demonstrable behaviours that speak to caring? A leader demonstrates caring when she makes herself available to share expertise with the nurses she supervises. When she is sympathetic to the plight of others not so fortunate. When she demonstrates — by expressing, through words or actions — real empathy, in the form of concern, support, and understanding of others. When she expends time to ensure that meetings are efficient, effective and meaningful to participants. When she engages in dialogue with people throughout the organization about what caring means to her, and allows them to express what it means to them. When she gives people time to share with each other their purpose stories. When she delivers praise for a job well done. When she speaks up to correct injustice, either to a client or a fellow nurse. And when she deals appropriately with situations when the job is not well done (coaches, directs, disciplines).

Some of the strategies a leader employs in an organizational context to demonstrate care are reflected in the following actions. The creation of a process that allows employees and clients a say in defining the purpose of the organization, as well as how that purpose should guide decisions that affect their work. The establishment of evaluation and accountability mechanisms that provide feedback on whether or not the purpose is being achieved. The development of communications systems that seek feedback from clients and care providers and that provides information they need to do their job. The development of processes that delegate to others the authority that their expertise and scope of practice requires them to have. The development of a process that will guide the allocation and redistribution of funds. And most important of all is the ability to stick consistently with those processes and methods and to conduct oneself in a manner respectful of them.

III. My Hopes

The seven C’s of caring leadership are, of course, a creation of my own doing. They represent dimensions of style, motive, and behaviour that need to be emphasized by all of us as we attempt to enhance the quality of health care in this country. But I can’t take credit for them. They were inspired by the nine nurses who wrote insightful, introspective and meaningful articles about leadership in this book. So to honour their significant contributions, I would like, in closing, to leave you with three suggestions that occur to me as a consequence of their analysis of the system’s needs, and that may well be fundamental to the future of the Canadian health care system.

1. Self-Care

Self-care is essential for nurses today. To achieve self-care “personal leadership is the place to begin,” as Kim Dougherty reminds us. Have compassion for yourself. Use your own reserves of character to find the courage and fortitude to sometimes put your feelings and your needs first. Commit to taking time in your day to remind yourself of the fundamental purpose that drew you to your calling. Develop “soulguards”. Just as a bodyguard protects our body, we need soulguards to protect our soul. As you continue to re-discover your own passion, your own essential purpose as an individual, develop an awareness of what actions
or behaviours (yours or others) diminish or challenge that purpose. Recognize the signs of over-caring. Develop defenses. Spend more time with people who see your soul, and who share essential elements of it. Seek out activities to replenish your store of soul. Insist that others create space in the day to dignify soulwork. Consider implementing Practice Circles®, or other techniques that build upon the concept of dignifying soul. Talk with others about what is important to you. Share your talents, abilities, techniques and gifts with others. Care for the caregivers, beginning with yourself. All these are fundamentally important to the future of health care in our country.

2. You are not "just nurses"

James Kouzes once said that the first step to becoming a leader is to want to (see Kouzes & Posner). Sometimes nurses feel that they don’t have the power or the formal authority that goes with the title of leader. But in reality, management has no power without nurses. There is no health care system without nurses. Nurses have huge potential power. But they also need to want to lead.

Kim Dougherty is extremely insightful when she quotes Nelson Mandela who states that most people have a deep fear of taking on the true responsibility of leadership. It is easier and more comfortable to grant our own leadership responsibility to someone else, and then blame them when things go wrong. Nurses must use the power they have to improve the health care system. They must use the power to shape conditions in their own worksite. Demand to be involved in organizational decision making. But do so with the simple recognition — in keeping with the concept of connections and interdependence — that others also have power. And their power is essential too. So be prepared to let others lead when appropriate and to lead yourself when appropriate. And develop the capacity to know the difference. Don’t get caught doing just one or the other. Practice the Goldilocks form of leadership: not too much, not too little — just right!

To this end, nurses need to ask for, pursue and gain the responsibilities in the health care system that are commensurate with their talents and abilities. We can no longer afford to run a system that does not take advantage — to maximum efficiency — of the skills people bring to the table. If this means re-negotiating the role of nurses in client care, then it must be done.

3. Learn, Learn, Learn

The final suggestion to "learn, learn, learn" is almost self-evident. In modern day medicine — where re-structuring is a norm; where medical technology is burgeoning; where knowledge almost doubles yearly, and in which electronic media have captured the marketplace — one cannot function in one’s work without dedicating oneself to continuous learning. Yet this is a quality that current organizations — and many individuals — resist with vigour.

The resistance is not necessarily knowing resistance. Much of it is a product of old ways of conducting business. But much of the old styles of decision making, of communications, and of exercising authority were designed in an industrial world that operated at the speed of sound. There was always a lag between the creation of a thought and the communication of that thought. In the information age, we operate at the speed of light. There is no lag between the creation of a thought and the communication of that thought. As a consequence, change is happening — in appropriate medical technique, in emerging trends in the marketplace, in knowledge of best practices — at a pace that requires continual adjustment of skill and experience. Caring leaders today must encourage themselves, their colleagues, and their organizations to learn every hour, every day, every year. To do so, individuals must seek out learning opportunities in their daily work, set up continuous learning mechanisms in meetings and in interactions with fellow-workers and clients, and continually access meaningful formal education and training opportunities to enrich workplace experience. Of course, the internet is both the cause and potentially the solution of the
information/learning phenomenon; each of us must be learn to use that environment in our work.

**Conclusion**

In summation, let me reinforce the three main themes that permeate this book. The first is that the concepts of *health, leadership,* and *care* define the kind of leadership required to steward the Canadian health care system into the future. Explicit within this theme was that the soul component of health be an area of enhanced focus for leaders. The form of leadership that puts equal emphasis on body, mind and soul is called *Caring Leadership.* Caring leadership, as a construct, has implicit within it seven fundamental qualities: compassion, character, connections, creativity, commitment, cooperation/collaboration, and competence. It is through the behaviour of individuals in the health care system that these qualities become influential.

A second key theme is that nurses who helped create this book generated this approach to leadership. They have provided numerous suggestions as to what is important in health care leadership, and what practicing nurses can do to exercise the kind of leadership required of them. The final theme is that for nurses to take on the mantle of leadership — to position themselves to realize their leadership potential — they need first to take care of themselves; second, to recognize and operationalize the power they already possess; and third, to be prepared to continually learn.

I know myself that I have great hope for the health care system as a consequence of this book. Hope because nurses are so committed to caring; hope because there is a huge latent power for leadership in the nursing cadre; and hope because the kind of leadership that is required springs naturally from the foundations of nursing itself. We end our book on this note of hope.

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**References:**


The contributors to this volume are faculty or participants in leadership programs at Royal Roads University. The University wishes to acknowledge their continued efforts to advance leadership within the health sector of Canada.

Royal Roads University is dedicated to continuous innovation in leadership and learning. Commensurate with this vision, the Organizational Leadership and Learning Division offers both Executive and Masters programs in leadership to clients from the public and private sectors.

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