Chapter 3

Educational Drivers to Leadership

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OUTLINE

Educational Pathways to Nursing Leadership

The educational pathways to becoming a registered nurse have evolved over the last century from fully clinically oriented and ward management hospital-based training to more liberal arts and science education, which provide the underpinnings for nursing theory-based practice. Nurses receive their education in 2-year and 4-year colleges, in universities, and even now in some hospital-based schools. For the most part, colleges award degrees to graduating nurses who must then pass the NCLEX-RN examination in order to obtain their license to practice.

The 2-year graduate earns the associate degree, which is the most common preparation for nursing practice in the country. The 4-year graduate generally earns the baccalaureate degree. The members of the nursing profession have

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always worked actively to provide opportunities for educational advancement for nurses. Transition programs from ADN to BS (N) and from ADN and BS (N) to MS (N) are common. Programs for nonnurses to MS (N), and to one of the several doctoral program types within nursing, are also available and increasing in popularity.

The nursing theorists studied within these programs write of various views and predictions of the nurse–patient relationship. Other theories that support the development of the leadership role beyond clinical practice are described within this chapter. As aspiring leaders, it is essential that nurses actively build an integrated composite of leadership theories that focus on achieving growth and integrity in healthcare delivery systems.

Building a broad and powerful theoretical base to assess, manage, change, and evaluate both educational institutions and healthcare delivery systems, and the individuals and communities they serve, is a challenging and exciting undertaking for the nurse committed to making change at all practice levels. The nurse who can do so will be an influential and successful leader. This chapter offers some views on the various aspects of the educational pathways to nursing and the leadership roles that must be an active and growing part of our profession. Accordingly, the purposes of this chapter are threefold: to analyze educational pathways for nursing leadership from basic to advanced degrees, to analyze the theories that support effective leadership practice, and to illustrate components of a multifaceted profile of nursing leaders.

Historical Summary

Before the 1870s, nurses with any kind of education or training were virtually unknown in the United States. Indeed, the practice of nursing was seen as a menial occupation, carried out by lower-class women from impoverished or criminal backgrounds. Wealthy men and women outside the health professions who were committed to healthcare reform first advocated the need for nurses with education (Starr, 1984). Florence Nightingale described the nurse as one who would "put the patient in the best condition for nature to act upon him" (Nightingale, 1992, p. 75). Throughout the world and the ages, the idea of the nurse is based on maternal instinct, caring for the suffering, nurturing of children, and service in the community, as well as in the hospital (Donahue, 1996).

In the first 70 years of the 1800s, physicians gave lectures to nurses and midwives at state hospitals. There was, however, no formal curriculum for nurses. By the mid-1800s, there was a growing awareness of the need for schools to be formed to educate nurses to care for the sick. Early programs of study in the United States were at Bellevue Hospital, the Connecticut Training School for Nurses, and the Boston Training School for Nurses (Kalisch & Kalisch, 2004).

During the latter half of the 19th century, Florence Nightingale was the catalyst who transformed nursing into a respected and education-based field of endeavor. She wrote extensively about hospitals, sanitation, health and health statistics, and nursing and nursing education. The school she founded in 1860 offered a curriculum that included theory as well as practical experience (Ellis & Hartley, 2004). The theory portions of the schools were 1–2% of the total required hours, and the practice hours were 98–99% (Kalisch & Kalisch, 2004).

With growing pressure to meet the need for public health and school nursing in the beginning of the 20th century, and the demand for

educated nurses to treat mass casualties and related disease on the battlefield in World War I, and eventually World War II, nursing education began to move to academic institutions where bachelor's degrees were given, along with diplomas.

The Goldmark Report of 1922 became a catalyst to further reshape nursing education toward theory-based practice. In-depth study of the theory of disease and the psychological and social aspects of patient responses began to shape the core of nursing education. Those graduates who were at the forefront of this nursing education revolution were identified as the leaders in the profession. The early collegiate programs generally consisted of two years of general education and three years of a conventional 3-year diploma program. Integration into a liberal arts and science-based nursing education, which led to theory-based practice, was yet to come. The nursing education programs preparing leaders of schools and colleges of nursing and nursing divisions of complex healthcare delivery systems were rudimentary at best.

The creation of a curriculum guide by the National League for Nursing Education and the demands for educated nurses for World War II escalated the training programs but not the benefits of a profession on the move. The wonder of these nurses was their ability to care for brutally injured causalties, day and night, beautiful in the midst of horror, smiling for the troops.

The Brown Report of 1948 set the stage for far-reaching changes in nursing education and nursing practice. It called for nursing as a professional education, accredited by nationally known, recognized bodies, where the outcome would be excellence in practice in a changing post-war health delivery system. This report also served as a change agent to guide the profession through the dictates of physician oversight and administrative rigidity in the practice of nursing. The Brown Report marked the beginnings of a vision of nursing leadership beyond the direct practice of patient care. The vision of managing and shaping professional nursing practice, intertwining the uniqueness of nursing with that of medicine within an administratively supportive environment, was critical to ensure the growth in depth and complexity of nursing practice and to deal with a new era in healthcare delivery.

The Brown Report came at a time when the number of nurses was declining. After the war, a nursing shortage resulted from the long and arduous working hours, low pay, and limited power and authority to shape a supportive and encouraging environment for the profession. The nursing shortage persisted through the 1950s, and efforts were under way to increase enrollment in nursing schools. Schools of nursing across the country were building stronger, more integrated baccalaureate programs, and nursing science began to emerge as the core of nursing practice, separate from the approach of a compilation of related sciences.

Modern Age of Nursing Education

Those entering practice roles in nursing are required to have specific basic educational background and usually prior professional experiences as well. All nursing leadership positions require licensure in the state of employment and a degree in nursing, traditionally the bachelor's or associate degree. More recently, nursing programs have expanded to attract those from other careers into nursing. For those who have a college degree in a nonnursing major, some programs offer basic

nursing education as required for licensure in a graduate level (master's) program. However, the common core remains: the nursing license and basic clinically oriented nursing education.

Because there are several routes to achieving the common core, it is debated as to which is the most valuable and common pathway to a basic nursing education. The two most common routes are the bachelor's degree with a major in nursing (resulting in a Bachelor of Science with a major in Nursing, or BSN) and the associate degree with a major in nursing (resulting in an Associate Degree in Nursing, or ADN). Note that the degree earned may read BSN or BS, depending on what the school is authorized to award. The same interpretation is made for the MS or MSN. The growth and development of the educational and experiential credentials necessary for the practice of the nurse leader have occurred intensively over the last 50 years and reflect the evolving curricula and learning expectations at all levels of study.

In the 1950s and 1960s, basic education for nurses was offered predominately through diploma schools of nursing, which were usually housed in hospitals (Kalisch & Kalisch, 2004). However, during those years, a new version of nursing education evolved as a result of the growing interest of potential nursing students in achieving a combined general and professional education. This interest led to the creation of baccalaureate programs that were essentially competitive with the diploma school market. The growth of baccalaureate nursing programs began in earnest in the 1960s.

Around the time the surge in baccalaureate programs occurred, a new type of nursing education program emerged: the 2-year associate degree program. This new educational venture prepared bedside nurses in a 2-year period to reduce the extreme nursing shortage of the time. It also moved nursing education squarely into the American higher education system (Kalisch & Kalisch, 2004). By not requiring four years of education, as did baccalaureate programs, associate degree programs offered an approach leading to a college degree in two years that could compete with the traditional hospital-based schools.

The associate degree programs existed on college campuses, offered more theory and science as a basis for practice, and required fewer practice hours than hospital-based schools did, but geared the clinical hours toward experiences that were necessary for learning rather than apprentice-type service. Theory consisted of both nursing content and liberal arts and sciences. In those early years, two-thirds of the credits nurses earned were nursing-related, and 75% of those were for clinical practice. Although the percentages have changed over the years, the focus of modern associate degree programs remains the preparation of clinically oriented bedside nurses. A key component of the associate degree structure was that graduates were eligible to sit for registered nurse licensure. Since the 1950s, nursing school graduates from 2-year, 3-year, and 4-year educational programs can sit for the same licensure exam.

The success of the associate degree programs was evident in the fact that a large percentage of graduates passed state licensing exams on their first attempt. This program type moved nursing into the community college setting as an acceptable and common degree area. Curricula were arranged so that bridge programs to institutions of higher learning were commonplace, although sometimes complex. Because associate degree programs are offered in local community colleges, they tend to draw students from local areas

and these students, once graduated, work in local healthcare delivery systems, thus continuing a cycle that alleviates a nursing shortage.

The market for associate degree programs was competitive not only because potential students were interested in a different type of nursing education, but also because hospitals that housed diploma schools were beginning to develop affiliations with local colleges and universities and to make placements for this new type of nursing student. Hospitals found ways to move nursing diploma programs to external entities. The primary driver for this exodus was the cost of supporting nursing schools, which was becoming prohibitive and causing hospitals to pass some of the costs on to patients. Affiliation agreements with local education institutes eliminated this burden (Kalisch & Kalisch, 2004).

The change in environment for nursing programs lead to a shift in the new type of nurse graduates away from the more traditional, subservient role to one of greater education and self-development. The new programs emphasized individual education and growth as well as nursing skills and abilities. Nursing education became a liberal arts–based profession. Thus began a significant change in nursing education that prevailed and continues to this day.

Nursing education came to encompass expectations for greater clinical decision making and an understanding of trends, issues, the place of research in nursing, the role of nursing in the community, and the patient teaching aspect of nursing. Both associate and baccalaureate programs, to greater and lesser degrees, provide nurse education founded on liberal arts and science education and an understanding of the independence and interdependence of the profession. In addition, both provide the educational basis necessary for graduate education.

The Issue of ADN versus BSN as Entry-Level Education to Nursing

Many members of the profession believe that the baccalaureate degree offers broader, more relevant education to practice nursing in the complexities of the current healthcare environment; it should be the only entry into practice degree. The baccalaureate degree is advocated as preparation for administrative and teaching roles, although the master's degree is often a requirement for assumption of these positions. It is also advocated for community-based roles. The baccalaureate graduate at the bedside is also an espoused goal of most clinical facilities.

There is still division in our profession about what is the appropriate entry-level degree, and why. Other members of the profession believe that the associate degree is sufficient for full entry into practice in all clinical positions, including critical care and community-based roles. In addition to the confusion within the profession, employers are also unsure as to what the differences are. The differences are not necessarily recognized in the various job descriptions and accordingly are not being formally utilized or recognized.

The question of which degree is best for different purposes and opportunities is an issue that requires research and forums for debate and discussion. Nursing is too scarce a resource and too valuable a practice to have continuous confusion and division within and outside its ranks. As a profession united in beliefs about our education and practice, nursing leaders will be better able to advance through the ranks of very complex institutions and influence achievement of fully developed theory-based practice.

Undergraduate Issues

A significant percentage of associate degree graduates do not continue their education. Approximately 60% of all registered nurses in the United States are graduates of 2-year programs, making them the backbone of the registered nurse population. In addition to the brief period for schooling and credible National Council Licensure Examination (NCLEX) results, associate degree programs offer the education at less cost than 4-year programs do. With more focus on bedside care in these intense but brief educational programs, the vision exists to prepare associate degree graduates for senior nursing leadership positions in complex, multifaceted institutions. The vision is complicated by the need for additional education and perhaps by the goal of retaining greater numbers of associate degree graduates at the bedside.

Baccalaureate education provides a strong liberal arts and science base, multiple opportunities for student leadership roles, great exposure over a longer period of time to the personal and professional benefits of higher education, and a clear vision of a future based on continuing graduate education. Associate degree education offers an intense but shortened liberal arts and science based nursing curriculum that fully prepares nursing students to sit for the same licensure as baccalaureate graduates, who are often competitive for the same positions and most likely earn the same entry salaries.

Whatever the outcome of the debate, the present status supports that associate degree program graduates enter the workforce in critical care, emergency care, and community health positions. The nursing shortage has increased the hiring of associate degree graduates into positions other than basic care, as was the original idea of such programs, and which is still stated in contemporary writings (Cherry & Jacob, 2008).

Entry-level salaries have increased over the years in nursing. What has been much slower to move upward is the ceiling for nurses' salaries. Clinical nurses who reach their ceiling salary and wish to stay in nursing and advance to teaching, administration, or advanced practice positions find, at that point, the education needed for advanced positions is time consuming, often moves in a step-wise progression, is expensive, and does not necessarily recognize prior work experience for academic credit. In 2005, of the 2.9 million nurses in the United States, less than 50,000 reported holding a master's degree. Only a very small number of nurses had earned doctoral degrees, although the number has gradually increased since the 1980s.

Master's Education Issues

Creative and credible methods of recognizing advanced learning, assessment, and evidence-based practice are developing. More opportunity than ever now exists for advanced practice education. These are strong trends to bring nursing leaders into the boardroom from the bedside workforce. These are positive trends. In an age where nursing resources are scarce, where experienced nurses sometimes leave nursing or move from organization to organization, creative, effective, and efficient solutions for advancing education are essential.

Moving nurses from clinical roles to executive level positions must be an intense priority undertaken by the profession, with a commitment to achieve clarity as to what education is necessary,

and efficiency as to eliminate any redundancy in steps taken by potential leaders. The transition needs to be efficient, effective, and focused on the learning needs that executives will have as they assume the highest leadership roles in the complex, changing environments of fully integrated healthcare enterprises.

Healthcare institutions will benefit greatly by further developing roles, compensation, and scope of authority and responsibility for nurses with higher education. Institutions that develop such frameworks for success will see benefits in patient satisfaction, quality of care, and cost effectiveness.

Some are concerned that nurses are moving too far from their original calling as bedside nurses. However, leaders, managers, and teachers of nursing are essential if the profession is to lead healthcare delivery in the present and into the future. These concerns are somewhat addressed by the preparation of clinical experts such as nurse practitioners in master's level academic programs.

Academic credentials and/or professional certifications are required to ascend to leadership positions. So, while they are still evolving and becoming further refined and defined, the requirements for earned degrees and/or certifications are accepted as sine qua non within the professional role. On the one hand, the major nursing organizations, including the National League for Nursing, American Nurses Association, American Association of Colleges of Nursing, as well as the State Boards of Nursing and its overarching National Council, are key players in determining the requirements and education for clinical practice at basic and advanced practice levels.

Today there are articulation models in the form of ADN to BSN programs, and RN (usually ADN graduates) to master's degree programs in nursing. From a professional advancement standpoint, the articulation models are supportive to enhance theory-based advanced practice. The practice roles are in a variety of areas, most often for nurse practitioner roles. The focus of education roles at the graduate level is most often required for undergraduate faculty positions, and sometimes for staff development education. The management or administrative focus of graduate programs offers preparation for those in the nurse manager/director/vice president pathway.

There is still debate as to what material formal educational processes must contain to prepare the advanced practitioner to move to higher and broader leadership responsibilities. Does the formal preparation of nurses to be educators also prepare them to be deans or academic directors? What is the profession's academic mandate to shape nurses for senior academic leadership positions of vice president and president? Do the requirements for such learning belong at the master's or doctoral level of education, or both?

For nurses who wish to reach the highest levels of leadership in the clinical role, the road to practice with power has yet to be fully paved. However, there are newer efforts in this area that are worth considering. The prevailing clinical roles for the advanced practitioner have effectively become the nurse practitioner, certified registered nurse anesthetists, certified nurse–midwives, and clinical nurse specialists. The 30-year effort to move the role—especially that of the nurse practitioner—into the mainstream of the healthcare delivery system is an honorable success story for the nursing profession.

The roles of most of the advanced nursing practices are widely recognized and supported

by the insurance, medical, healthcare delivery, governmental, and legal communities. The uphill battles began approximately 30 years ago to move the outlier idea for the nurse practitioner role to the mainstream where it has become a pivotal and powerful role for cost-effective, high-quality practice with a recognized outcome of patient satisfaction as well. Achievement of recognition outside the profession is evident in alterations in the practices of healthcare delivery, such as separate licensure, specialty certification, prescription privileges, and insurance reimbursement. Within the profession, recognition of achievement is by the expansion of the role from solely outpatient-based to a variety of inpatient roles, responsibilities, and titles. Nurse practitioners may practice autonomously, with or without direct physician supervision, or within institutions.

With the evolution of this nursing role, the power to control practice via independent management and decision making as a nurse practitioner is still a work in progress. The decision-making power to use institutional resources to enhance practice and/or bring together multidisciplinary healthcare teams to achieve goals for patient care such as treatment, cost efficiency, or quality improvement must expand if nursing is to lead healthcare delivery in a clinical role. To this end, what are the next formal educational pathways the profession needs to set to enhance the scope of practice and the authority of the nurse leader in a clinical role? Are there formal academic experiences that are essential to prepare the most effective nurse leader in an academic setting? How do we, as leaders of the profession, better shape the formal pathways of education for nursing leadership in the boardroom?

The Politics of the Doctorate in Nursing

The doctoral programs in nursing (Doctor of Philosophy, or PhD; Doctor of Education, or EdD; Doctor of Nursing Science, or DNS/DNSc; and Doctor of Nursing Practice, or DNP) and those that are related, in such areas in the social and behavioral sciences, provide formal education at the highest level. The primary focus at the doctoral level has long been the expansion of knowledge frontiers through the research process.

The DNP is designed to prepare nurses to provide inpatient clinical care, oversee the care of patients, and make independent decisions about care. There has been concern about whether the DNP expands knowledge through research. In partial answer to this question, it is important to note the efforts now under way by the American Nurses Association to lead support for the implementation of the role of Doctor of Nursing Practice. ANA has promulgated this role to "ensure that all patients have access to affordable healthcare benefits and services, and the ability of all health professions and organizations to innovate and improve quality of care" (American Nurses Association, 2008).

The American Medical Association has written of its opposition to this new form of nursing education at the highest level unless DNPs practice under the supervision of a physician and as part of a medical team in which the final responsibility for the patient lies with the licensed physician. Furthermore, the AMA has stated opposition to the participation of the National Board of Medical Examiners in any credentialing process for this new, highly prepared practitioner in nursing (American Medical Association Houses of Delegates, 2008a). Further potential confinement of nursing prac-

tice is stated in the following resolution: "The title of 'Doctor' in a medical setting applies only to physicians licensed to practice medicine" (American Medical Association Houses of Delegates, 2008b).

The ANA responds to these views by firmly stating that the American Medical Association does not regulate the practice of nursing, and that it is inappropriate for the organization to try to limit the scope of practice of another profession. It is essential that the two professions work collaboratively—with neither determining the scope of practice of the other—to provide an environment of quality and successful outcomes in the healthcare delivery system. The outcome of this territorial issue will eventually be resolved. With the full and consistent voices of the nursing profession, the growth of responsibility and autonomy for practice will prevail.

Education and Experience for Leadership

Entering the realm of leaders also requires that individuals bring a range of professional practice experiences to the leadership role. The responsibilities, skill sets, depth of organizational and professional knowledge, and span of control exercised by the nurse leader prior to beginning any new position are key components of the practice pathways to leadership positions in nursing. There is variability in what comprises the ideal or expected aspects of the practice component to support ascendance to the leadership role.

Nurses with a combination of graduate-level education in nursing or other fields and appropriate practice experience as advance practice nurses, nurse educators, nurse administrators, or nurse informatics specialists can become candidates for leadership positions, up to boardroom-level positions, even though their educational preparation may have been mixed with nontraditional credentials. In some sectors, there is continuing debate on how much "mixing" of nursing and nonnursing academic and practice credentials is acceptable.

There are two other components to consider in laying the groundwork for pathways to leadership roles in nursing. One is the focus and structure of the healthcare organization, which may provide patient care services, be an academic institution, and/or function as a for-profit vendor of services. Within the institution, the role of leader will reside at some level in the organization, thereby indicating the leader's span of control and where on the practice-management-leadership continuum the position resides.

The second component is the actual "meat" of the meaning of the leadership role as it relates to the institution and to the position. In all areas of nursing practice, from patient care to research, from teaching to administration, the behavior of the nurse leader reflects certain capabilities and characteristics that are identified with leadership. Examples of some common characteristics often associated with leadership are excellence in practice, strategic planning abilities, ability to make and manage change, communication skills, and ability to build an effective team.

One other consideration in creating the profile of the nurse leader, which will influence the preceding components, is the fact that the nursing leader may not move on the pathway to a nursing leadership position. Rather, such an individual may choose a leadership trajectory in a different field such as politics, law, or business. Box 3–1 introduces a nurse leader who is involved in politics, too.

Box 3–1 The Honorable Claire Shulman

Claire Shulman

Claire Shulman is a nurse and a politician. She remains actively involved in health care through her affiliation with the Queens Hospital Center. Among many awards Ms. Shulman has received, she most recently received the Lifetime Achievement Award from the Alpha Omega Chapter of Sigma Theta Tau and the Adelphi University School of Nursing.

In her own words…

"I was a nursing student at Adelphi College School of Nursing (later to become Adelphi University). As a student, I was affiliated at Queens General Hospital Center as Adelphi College had no hospital. I was a student during the war, and students ran the hospitals under the supervision of a nurse supervisor because the registered nurses were in the service. (That's why we learned so much—because we had no alternative.) Our country was engaged in World War II, and consequently we had very little in equipment. As students, we quickly learned to improvise and became nurses extraordinaire.

I graduated from Adelphi College in 1946 with a bachelor's degree, and I passed state boards shortly thereafter and became a registered nurse. My first job was in female medicine, and because of my degree I became head nurse at the ripe age of 21. I nursed until 1950 when my first child was born, and then again after the Korean War.

When my children entered school my political career began. After working in government for some time, in 1986, I became the Borough President of Queens County, New York City, and served in that capacity for 16 years. Because of my nursing experience I always paid very close attention to details, particularly in areas related to health, and was able to accomplish many things for the public including rebuilding the Queens Hospital Center, which today is the newest and best in the New York public hospital system.

My nursing experience has been invaluable in my life and has helped to govern almost everything I do. My values were created on the hospital floors as I dealt daily with life and death issues, and I have passed on these values to my family."

The pressures of the healthcare delivery system and the academic institution shape the leadership role in today's healthcare environment. These are the two major healthcare-related entities in which the nurse would typically practice. The mission and vision of the institution shape the role. The behaviors of the nursing leader are to provide vision and a strategic plan to accomplish the mission. The boardroom leader has overall responsibility to develop a resource base sufficient to support staff to meet customer needs and must commit to creating and energizing a dynamic whole within the diverse and complex staff. Overall, nursing lead-

ership, with the help of management, has the awesome challenge of charging the energies of those around them to maintain the essence of the institution and the communities it serves.

Education and Skills for Leadership Practice

Nurse leaders must appraise the complexities and identities of the institution and the community as individual force fields. They must value and construct opportunities for energy exchanges between the institutions and the communities they serve for the betterment of both. These tasks require knowledge, wisdom, sensitivity, and a spirit of inquiry to bring ubiquitous energy together for outcomes that can be measured and valued by those involved.

The nursing leader's appraisal can focus on constructs such as diversity, community study, staff understanding, resource building, education, knowledge and skill building, communication, respect, and understanding. The focus of the nursing leader's actions is to support, assess, change, maintain, value, and select.

The tools of the leader are nursing knowledge and skills, experiences, and practices that emerge from behaviors and roles in complex institutions that serve heterogeneous populations. Analytical, judging, and investigative skills support inquiry and evaluation, questioning, and proposal development. Designing interactions to improve the providers' contributions and the customers' outcomes will occur when the integration of the preceding functions results in the ability to predict successful outcomes accurately.

The focus of graduate preparation in the academic environment is on learning requirements necessary for curriculum development, teaching and evaluation, and creatively managing student-learning needs.

Programs in administration in the healthcare delivery environment have expectations for knowledge and skill in developing and providing the resources to implement evidence-based practice protocols, managing teams, managing conflict and change, and creating an environment for care that strengthens patients and staff.

Education for advanced clinical practice prepares the nurse for a higher degree of autonomy and interdependent practice and teaches advanced clinical skills in patient assessment, treatment, and evaluation. The clinical doctorate is specifically designed for the nurse to function in clinical leadership roles in patient care situations. The newer advanced practice role in informatics focuses on Information Technology as a force within healthcare systems, designed and utilized to enhance patient care and the practice of nursing and other health-related professions. Advanced practice in informatics will enhance the creation of nursing databases and document the influence of nursing practice on patient outcomes. This information should be the basis for designing cost-effective patient outcomes while enhancing patient satisfaction and utilizing nursing abilities to the fullest.

Theories of Nursing for Clinical Practice

As nursing moved into academic settings and to professional status, one of the areas of growth was the development of theories that explained and predicted the practice. The theories of nursing, perhaps two dozen or more, focus on the nurse–patient relationship. The relationship is postulated and investigated to facilitate better

understanding and to generate further postulates on achieving opportunities for healthier growth in patients and nurses. Research to test the theories to expand nursing's borders is a major focus of graduate programs in nursing.

In 1964, Martha Rogers's *Reveille in Nursing* not only marked nursing as a profession with its own scientific base, but it significantly reinforced the concept of graduate study in nursing as the sine qua non for the clinical practice of nursing and set the stage for leadership in the profession (Rogers, 1964). At last, nurses could refer to their own scientific base and build on it to explain behavior and to prepare appropriate approaches to achieve desired outcomes. In her statement, "The body of knowledge made explicit by nursing's scientists and researchers must be transmitted if the conditions of the profession are to be fulfilled," Rogers puts forth that nursing as follower or leader, in the clinical, teaching, or administrative role, has its own theoretical paradigms on which to base its assessments, plans of action, behaviors, and evaluations of nursing interventions (Rogers, 1964, p. 43). The educational pathway to leadership took a significant step forward in the 1960s and 1970s by elucidating theoretical frameworks for nursing and, equally important, clearly showing that the universe of nursing contained leadership and change agent roles in all settings and investigatory research roles.

In the 1970s, Dorothea Johnson proposed the Behavioral System Model that postulated that nursing practice should focus on the patient as an individual, rather than the disease, and should facilitate effective behaviors in the patient before, during, and after illness. Motivation, adaptation, and the change process can achieve her interpretation of the interactions in human systems and subsystems to achieve better functioning.

Sister Callista Roy put forth the Adaptation Model as a theory of nursing practice that focuses on promoting and expanding adaptive abilities. Roy's model, which evolved from behavioral and social sciences, sets a framework for clinical nursing practice to work with patients via environmental alteration to help patients develop their own adaptive behaviors leading to survival, growth, reproduction, mastery, and other aspects of transformation. The role of the nurse is proactive, to assess, evaluate, and manipulate stimuli in the patient's environment. Roy's approaches to enhance the transformation and change that occur in the person and his or her environment provide clarity to the nursing process and an important aspect of meeting patient care needs.

Martha Rogers expanded on *Reveille in Nursing* by creating a theory widely known as the Science of Unitary Human Beings. Her conceptual model emerged from the wide knowledge bases of multiple disciplines, including anthropology, biology, physics, and philosophy. She broke new ground in using these theories to explain the relationship of human beings to their environment and how the two forces interact with each other, affecting change through the experiences that occur. According to Rogers, the role of nursing is to "strengthen the integrity of the human field" and to direct and redirect "patterning of the human and environmental fields for realization of maximum health potential" (Rogers, 1964).

A more recent theory of nursing called Nursing: Human Science and Human Care, postulated by Dr. Jean Watson, identifies caring as the essence of nursing (Watson, 1985). Watson defines caring as a moral behavior and goes on to describe caring moments and the phenomena of the relationship between caregiver and patient. Her insight into the power of the relationship as the environment to enhance growth in the patient is a powerful active behavior of nursing practice. Her theory of caring high-

lights the creation of energy forces such as values, faith, hope, and sensitivity to self and others. These forces are drivers of health and growth in the patient and indeed in the caregiver as well. These forces generate helping and trusting relationships, and acceptance of both positive and negative feelings. The theory goes on to describe the creation of healing spaces and awareness and the development of the ability to honor what is sacred.

The theories mentioned here are but a few examples of credible and worthy theoretical constructs and paradigms written by nurse scholars. They provide a vision for knowledge-based clinical practice that, once tested and implemented, can become powerful tools for influencing and predicting positive outcomes of patient behaviors. The ability of nursing practice, based on recognized theory, to transform the patient system in positive directions strengthens our commitment to pathways to excellence in nursing care of patients and their families based on theory, the actions, and science, in turn also strengthens the profession.

Some theoretical underpinnings for the advanced practice role focus specifically on the role of the advanced practice nurse. According to Lucille A. Joel, theoretical perspectives of "structural-functionalist" and "symbolic-interactionist" will guide the advanced practice nurse (APN) to move the newer role into the mainstream (Joel, 2004). The structural-functionalist perspective guides the practitioner to the awareness that opportunities to alter roles already known (i.e., the traditional nursing role) are limited. The symbolic-interactionist theoretical perspective presents environmental forces as open to choose what they wish to react to, thereby laying the groundwork for acceptance and embracing the changing role of the nurse, from traditional to independent and proactive.

Evidence-Based Practice Approaches to Support Nursing Leadership

Advanced practice methodologies and evidence-based research, which have become hallmarks of quality nursing care, have theoretical underpinnings. They are integral to nursing practice at all levels. Practice based on researched clinical and nursing theory evidence is a powerful basis for the provision of patient care and increases the strength of predictable outcomes and observations. Furthermore, such practice enhances the power of nursing theories so that they more broadly influence practice in nursing and across disciplines. By bringing integrated theory to quantitative research testing, traditional nursing education and practice can move to the forefront in determining standards and protocols for practice that can achieve expected outcomes.

Evidence-based practice is the outcome of testing science and theory that confirms the most effective interventions and treatments for patient health issues. Evidence-based practice is based on more than the methodologically impeccable research work. It includes logic, critical thinking, and the most rational way to plan actions and make decisions (Jenicek & Hitchcock, 2005).

The major components of evidence-based practice, such as critical thinking and priority setting, are significant beyond the advanced practice role and are equally influential in graduate education and practice in education, administration, and management. The ability to think critically permeates all practice realms and can bring together the forces for change to enhance quality, access, cost efficiency, and social responsibility in the organization led by the nursing leader.

The leader is educated as a critical thinker. Disciplined, self-directed thinking considers

other relevant information, uses reflective skepticism to make overall judgments about the problem or issue, and acts appropriately based on reason (Jenicek & Hitchcock, 2005). Critical thinking is a persistent effort to examine beliefs and knowledge in light of the evidence that supports it. Critical thinking has also been described by Falcione as self-regulatory judgment, leading to evaluation and inference (Jenicek & Hitchcock, 2005).

Education for leadership, via modern pathways, must actively generate decision-making behavior based on knowledge, logic, critical thinking, and communication with the communities served by the leader. From this perspective, the current efforts of evidence-based practice focus within the clinical practice realm of the leader. However, it is also important that senior academic and organizational leaders have the capabilities to make knowledge-based decisions to achieve evidence-based practice. These decisions emanate from logical, reflective analysis. Once analyzed, the decision outcomes are communicated accurately and without emotion or confusion to activate resources needed for both change and the cohesion to achieve it (Jenicek & Hitchcock, 2005).

One of the best definitions of evidence-based practice states that it is "an approach to decision-making in which the clinician uses the best evidence available, in consultation with the patient, to decide upon the option which suits the patient best" (Muir Gray, 2001).

A spin-off from the growing evidence-based practice movement is evidence-based policy making. Related to other practices besides direct patient care, evidence-based policies will use the best current knowledge as the basis for effective decision making. The creation of evidence-based policies will move further to institutionalize cutting-edge practice that is based on research. Indeed, if evidence-based practice is an important criterion for assisting decision making, then the use of this approach must extend beyond the clinical practice realm and into all areas of management and leadership where decision making is characteristic of the role (Booth & Brice, 2004).

Trusted expert knowledge systems must become the basis for solving problems and reducing the risk of poor outcomes. Healthcare outcomes such as poor-quality services, high costs, limited return improvement in overall health or functionality, and poor customer satisfaction, all can be improved with science-based actions in expert knowledge systems based on the tenets of nursing theory and evidence-based practice approaches.

For those in management or leadership roles, the use of evidence-based practice is essential to enhance effectiveness, accountability, and transparency as well as the value of costs and resources expended in achieving expected results. Indeed, evidence-based practice focuses on effectiveness. Its consequent processes are identifying evidence, critically appraising the research, incorporating the research into guidelines for practice, making decisions, and evaluating the outcomes of the decisions (Booth & Brice, 2004).

The Role of Large Theories in Leadership Development

The importance of harnessing large theories that can explain and offer predictions of outcomes of changes implemented by leadership decisions cannot be underestimated. Leadership is the ability to direct energies of the system to achieve directed change and the ability to communicate

with and influence the behaviors of other interfacing and communicating systems.

Leaders have the potential to influence all aspects of the systems in which they function and over which they have control. The power of their effectiveness relates to their knowledge and understanding of unique and powerful forces within the system.

General Systems Theory

The general systems theory framework, which can be used to understand and categorize the environment of the healthcare entity and the community, is one of the broadest frameworks available to conceptualize the total organization. Nursing leaders can become skillful in interpreting and utilizing this theoretical framework to assess, compare, predict, and evaluate the world in which their influence will make a difference. Nursing leaders can develop worthwhile insight into how the organization operates and will be able to communicate those insights in a compelling fashion that will allow correction and maintenance to be ongoing with limited resistance.

Ludwig von Bertalanffy's general systems theory presents constructs of continuous energy sharing between and among sectors of open systems to attempt to achieve homeostasis, or balance, throughout the system or to achieve growth and expansion in the system, even with some disequilibrium. Energy, its transfer, and use that was not sufficient to produce growth could be dissipated and reduce the strength and effectiveness of the system, resulting in more chaos and less productivity (von Bertalanffy, 1972). In particular, general systems theory is both a model of reality and a way of viewing the living world.

The theory is overarching, and if the leader's influence is to encompass the broadest sphere of behavior, it must be overarching over all energy fields that can be included in the system of the healthcare entity and the community (von Bertalanffy, 1972).

The interactive behaviors of open systems and energy can be of considerable importance to nursing leaders in that their strategic behaviors will be directed to developing and operating successful healthcare delivery systems. To achieve that complex and continually evolving goal, the leader must be cognizant of the energy in the system—where it is coming from and how it is being utilized, transferred, and transformed. The success of healthcare organizations will depend on their ability to attract and utilize resources (energy), such as financial support of customers and the efforts (energy) of the employees.

The leadership team scans the internal and external environments and creates an environment that transforms the energies of customers and clinicians into realistic alternatives and solutions to meet the expressed needs of the customers via the skill and knowledge of the clinicians. All energy exchange must consider the characteristics of quality, value, and need for the service both from the perspective of the suppliers (the organization) and the customers (the customers and the community).

If the implemented solutions are not as good as competing alternatives, there is drain and loss of energy in the system that will weaken the healthcare delivery system. If continuous and pervasive, this could result in the organization's failure, leaving a vacuum into which competitors can expand. If implemented solutions are better than the competing alternatives, there is focused energy use and achievement of better balance with expansion capabilities; the system grows and thrives.

The key components of the system for healthcare delivery are the healthcare organization and the community. Both entities must function together as partners to achieve the development of healthcare delivery that utilizes professional energy and resources (skills, knowledge, and equipment, for example) to stimulate healthiness in the community it serves. Such healthiness can be identified as empowerment in healthcare decisions, knowledge of alternative healthcare treatments and behaviors, and opportunity to clarify and define healthcare needs that the community and individuals wish to be met through transformation of organizational energies.

Field Theory

Kurt Lewin's field theory also has relevance to leadership behaviors. It offers a perspective of a universe (the healthcare delivery system, which is the responsibility of the leader) and provides interpretation and a theoretical framework to identify and maintain or alter the "valence" of regions of concern. According to Lewin, a "positive valence" represents a region moving toward a goal, and a "negative valence" represents a region moving away from a goal (Deutsch & Krauss, 1965). Regions have tension, which is energy used for "locomotion" to achieve a change. When the goal is achieved, the regions move to a state of balance.

Using this framework, the leader has the power and could have the intent to create and clarify a "goal region" and provide the tension or expectation of goal achievement. If there is no perceived goal region, the individual's behaviors are seen as restless and movement is away from the goal, which becomes a negative valence or value as a result of the frustration and lack of direction. The creation and management of the forces to achieve change in the positive direction

of recognized need have always been a challenge for leaders. Using the tenants of field theory provides a resource to achieve vision and to support the staff at all levels in their energy use and reaching the goals they will achieve.

Chaos Theory

Chaos theory has a rightful place in the investigation of theoretical constructs that can become the tools of the successful nurse leader. Chaos theory has found its way into the nursing literature from time to time, most frequently in the psychosocial areas of nursing. Although originating from mathematics and science, chaos theory utilizes the complexities of interactions and constant change within a societal context to understand behavior. Understanding is the key to limiting the interpretation of the behavior as pathological rather than adaptive.

Chaos theory can be described as an extension of systems theory applied in it widest context. It can be the theoretical framework for assessing institutional dysfunction from all major components, such as the clinical systems, legal systems, and information systems, for example. The breakdown of these subsystems has wide and powerful effects on the individuals and community systems that depend on the support and curative services provided by the healthcare and/or educational system, which infuses energy for growth and health into the individuals and community in its network. Chaos theory can offer the skilled leader some analytical tools of insight and assessment that can validate the totality of the negative and even devastating experiences in the community of customers or the staff infrastructure of the institution.

In either case, the principles of chaos expand, and broader, more complex and powerful forces are necessary to reduce the multisystem dys-

function. Dysfunction is enlarged through diversity, and its solution is hampered by lack of knowledge and understanding.

Concepts of Social Responsibility

An evolving approach to a conceptual framework for leaders is beginning to appear in the literature under the umbrella title of Social Responsibility. From the writings beginning to emerge in this area, nursing leaders can use the viewpoints of achieving socially responsible care. Such a strategic vision will create a direction for their healthcare system that successfully and easily meets current and future needs of the organization to perform at a level of excellence. Achieving excellence in education of or directly providing care for the healthcare needs of complex and diverse communities is a significant and challenging focus for leadership in nursing.

To act in a socially responsible manner, the healthcare organization and the nurse leader inherently embody strategic approaches to management and care that is community focused. The organization develops a community relationship by assessing the following characteristics of the community it serves:

- What are the community's goals and needs, and how does the organization serve them? Determining the status of the community–healthcare organization relationship will take careful and wide scope of data collection and assessment. Interaction with community organizations and leaders on many levels will lead to some insight on this point.
- How does the healthcare organization attract the resources it needs to perform its mission? The overarching categories of resources are financial, support of its customers and expanding customer base, and quality and loyalty of its employees. What are the degrees of success and failure in each of these categories? In addition, what are the factors affecting the outcomes?
- How focused is the healthcare organization on continuous improvement? For the socially responsible institution, equilibrium is never fully achieved. Directing the process of improving quality requires skill, knowledge, commitment at a fully multidisciplinary level, and the resources to sustain continuous inquiry and problem solving.

The healthcare organization must continue to survey and interact with the environment, both internal and external, and fully develop its relationship with it. Beyond that, as a basis for a beginning, the nursing leader implements mechanisms to promote consensus among the individuals and agencies supporting the organization. A community focus creates a broad base of support to ensure that the healthcare organization will endure and be effective and responsible, even in the face of continuous change.

The Role of the Nurse Leader in Creating a Socially Responsible Organization

The nurse leader can and should be prepared to undertake and implement key actions to build and maintain the support of its influential

stakeholders. Whatever the level of responsibility or power of the leader, the nurse leader can do the following:

- *Implement boundary-scanning activities.* Boundary-scanning activities include deliberate efforts on the part of leadership and management to identify providers and customers and to meet their needs by bringing them together to reach consensus.
- *Develop community partnerships.* To develop community partnerships, nursing leaders must develop relationships with community-based programs, such as mental health care centers, early development and pediatric care centers, and long-term and geriatric care centers. Developing such partnerships means citizen empowerment, which is an essential ingredient to responsive community-based social responsibility. Partnerships provide guidance to the healthcare system to ensure that it stays responsible to the citizens it is committed to serve.
- *Look inward to the purpose of outreach programs.* Are outreach programs a way for the systems to expand themselves and diminish the individualities of the communities? Are they sufficiently open to identify patient needs and fill gaps in inpatient services? Do outreach programs perpetuate paternalistic roles? Moreover, in the end, are they successful?
- *Focus on creating power among the community constituencies.* The nursing leader can challenge the nursing staff and management hierarchy to produce healthy outcomes and healthy behaviors among the

powerless and to move the constituencies from a powerless to a powerful state in deciding about their own healthcare needs and approaches. It has long been known that the health status of those with the least power is unconscionably low. The significant signs of poor health status and low power are quite universal and can be identified as follows:

Violence

Dangerous housing

Teenage pregnancies

Drug overdoses

Alcoholism

In summary, powerlessness goes along with poverty of resources and spirit. Powerlessness from any and all of the above factors leads to increasing risk factors of preventable disease. The knowledgeable and astute nursing leader, prepared by broad-based education and experience, can create a nursing and multidisciplinary infrastructure that is diverse and knowledgeable enough to interface with community leaders and community members to identify the scope of powerlessness and the capacity of the community to care for its citizens.

The Nurse Leader as Nurturer

The concept of nurturer has prevailed as a significant identifier of the nurse throughout the history of the profession. I believe it is a key one to be valued, developed, and used in our future. Using that historical view of the nurse to facil-

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Box 3–2 To Better Serve: Sometimes Life Happens by Chance

Sue Buchholtz

In the 1970s, the first nurse practitioner program was developed. The effort was to provide care for an underserved pediatric population in the Midwest. There were too few doctors to serve the growing needs of communities as the population expanded. It was believed that trained, experienced nurses could act as the eyes and ears of the physician and report back abnormal findings. It was believed nurse practitioners could take medical histories and conduct physical examinations, do well-baby visits, and observe for any abnormal findings. In this way, more children could be evaluated and those that needed more treatment could be referred to the physician for further care.

Over time, the use of nurse practitioners proved so successful that it expanded to include the care of adults, maternal-child nursing, care of the mentally ill, geriatrics, and care of the frail elderly.

Multiple surveys have indicated that patients prefer the care of nurse practitioners, considering them to be more attentive, kinder, and caring. Furthermore, the use of a nurse practitioner is cost effective because it extends the care of the physician to cover a far broader range of patients than one physician can cover. Because nurse practitioners often serve in lower economic communities the service provided is invaluable to the public good and provides services that otherwise would be unattainable or unaffordable.

While working at a large state university, I became involved in writing the plan for a women's health nurse practitioner program. Although we were successful in having the program accepted, we were criticized because the three authors of the program were not themselves nurse practitioners. So, after swearing up and down that once I finished my doctorate I would never, ever go to school again, I found myself registered in a nurse practitioner program.

Returning to clinical practice from academia was the most rewarding and fun experience. I have always loved patient care. Even during my academic years, beside the didactic portion of the course, I always taught the clinical portion, wanting students to love being with the patients as much as I did. Now as a nurse practitioner I was back full time at the bedside and adoring every minute of it. I felt useful, empowered, and independent. I assessed patients, wrote orders, and followed the patients' progress. I talked to families, made discharge plans, educated those who didn't understand, and held the hand of those in need. I had extended the role of nurse to do more good, be helpful, and to serve more of those in need.

Although I never planned to become a nurse practitioner (they didn't exist when I became a nurse), sometimes life just happens that way. Sometimes you get lucky and a good thing happens so that you can do more to serve humanity and your chosen profession.

After more than 40 years of nursing, I have never had one day when I have been sorry with the decision of my chosen profession.

> I have often said that for some nurses it is a job, for others it is a career, but for some of us it is a calling. It is our mission to serve the most basic needs of others to make them feel safe and comforted.

itate leadership development in today's competitive and complex healthcare environment is a challenge and an opportunity for the contemporary nurse leader. How does leadership in nursing reflect both the capacity for nurturing and the ability for visionary decision making that creates sweeping organizational and professional change in the profession, in practice, and in healthcare delivery on all levels?

The concept of the nurse as nurturer is inherent in the clinical role and the education of clinical nurses. Nurse as nurturer was the quintessential vision of the nurse. As nursing education evolved to enhance the knowledge base and decision-making abilities of nurses, there arose a turmoil that, although theory was desirable, soothing, touching, and caring were what nursing was really about. The differences of opinion on this subject in the multidisciplinary healthcare and patient community persist to this day and present an even stronger challenge and opportunity to the senior nurse leader to integrate nurturing into the executive role.

How does the nurturing nurse leader bring about changes in practice to enhance an organizational structure where nurses can develop, test, and implement approaches to evidence-based practice? What are the operational definitions of the nurturing nurse leader? What are the educational pathways that lead us to achieve that end? Or is nurturing a personality trait innate to those who become nurses, one not necessarily learned? It is largely up to the contemporary profession and its leaders and members to reinforce the nurturing characteristic of nursing as both quintessential to its practice and integral to the science of its analysis and actions.

Summary

This chapter touches on the major components of the educational pathways to becoming a nurse leader. The development and mix of all experiences, standards of practice, and academic achievements creates a leader who is different, dynamic, powerfully rich in abilities, and changing. Early in one's career as a nurse, an individual may not envision a leadership role aligned in his or her professional direction. As the future unfolds, and this option becomes more visible, it is up to individual nurses to enhance their profiles through cultivating the strengths of knowledge, wisdom, experience, and personal growth along the lines of academic credentialing; in this way, nurses utilize theory as a basis for predicting and achieving the vision and mission of the institution that owns the leadership role.

It was through the creative and scholarly writings of nursing theorists that education for nursing leadership took on a new expanded meaning and value, yet stayed grounded in sensitive, gentle, and knowledge-based direct patient care. Through the writings and research of the 1960s through the 1990s, nursing found its center and began to use that center to create its own independent and interdependent pro-

fession. The pathway to leadership through education lies in paradigms and propositions of nursing and other theories.

The pathway of nursing education includes key stepping-stones that represent the knowledge of science and arts that support the nursing process. The value of nursing theories is that they provide tools directly related to the profession that can enhance nurses' abilities to apply the nursing process, including the ability to predict outcomes based on research findings.

QUESTIONS

1. The primary driver for beginning the exodus of diploma schools from hospitals was
   a. the cost to the hospital for supporting a nursing program
   b. an inability to attract interested students into programs
   c. a profound need for nurses
   d. women seeking new careers

2. Kurt Lewin's theory identifies tension as energy, which he relates to creating change. According to Lewin, a positive valence in change theory represents a region moving
   a. toward a goal
   b. away from a goal
   c. along a straight plane
   d. toward power

3. According to Kurt Lewin's theory, a negative valence represents a region moving
   a. toward a goal
   b. away from a goal
   c. in balance
   d. away from power

4. According to Kurt Lewin's theory, when a goal is achieved
   a. all regions disappear
   b. power will no longer be an issue
   c. the regions move to a state of balance
   d. chaos will be gone

5. Social responsibility of the healthcare organization and nurse leaders in communities is vital. Nurse leaders develop a community relationship by
   a. assessing the goals and needs of the community
   b. determining the status of health care in the community
   c. assessing how the healthcare organization attracts resources in meeting community needs
   d. All of the above

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