

*Academy Of Canadian  
Executive Nurses (ACEN)  
Background Paper On  
Leadership*

**“Towering Genius Disdains  
A Beaten Path”  
Abraham Lincoln**

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Nursing Leadership was identified as a key priority for the Academy of Canadian Executive Nurses (ACEN) at their annual general meeting on 29 April 2001, in Toronto. The Academy believes there is an urgent need to strengthen Nursing leadership in Canada. Dr. Mary Ferguson-Paré was charged with the responsibility of leading a task force to develop a background paper on executive nursing leadership. This paper will review Nursing leadership structures and behaviours essential for effective professional nursing and form the basis for recommendations to strengthen Nursing leadership in Canada.

**What is ACEN?**

ACEN is a national organization of Canadian executive nurses in academic healthcare environments, associated with university schools of nursing, who are accountable for strategic, operational and educational outcomes and hold senior responsibility for nursing practice. The Academy is a body speaking for the advancement of executive nursing leadership in academic healthcare environments. ACEN members develop strategies for the advancement of nursing practice, education and research. ACEN forges coalitions and alliances to influence health policy and set a new direction for healthcare in Canada to assure quality of care to the Canadian public.

The role of nurse executives in teaching facilities is to provide leadership for client-centred nursing practice within an academic environment where service delivery, teaching and research are integrated, each enabling and informing the

other. The development of scholar practitioners and a culture of inquiry in the workplace is a key priority. These practitioners identify questions for research, participate in design and carry out research, which in turn informs practice.

Nurse executives in teaching facilities are expected to provide leadership for the future development of the healthcare system and influence the political system as well as champion the unique contribution of Nursing. We are expected to lead as well as develop leaders within the organization and the profession; to create an environment, in partnership with our faculty colleagues, conducive to the development of future practitioners, educators and researchers; and to be the testing ground for research and the development of new knowledge in Nursing and the health sciences.

In her address to the National Nursing Leadership Conference, Nursing Leadership: Unleashing the Power, 12-13 February 2001, in Ottawa, Leah Curtin stated that there are three key requirements to moving forward: executive leadership, professional care and collaboration between the two. The work of this task force will focus on the advocacy imperative of the executive role for nursing practice and client-centred care, and will place nursing leadership squarely in the context of the profession and practice of nursing.

**What is Nursing Leadership?**

We believe that the nurse executive creates an environment that facilitates the expression of leadership and that leadership resides in every nurse. Nursing leadership shares similarities with other types of leaders, and is grounded or situated in nursing and the context of nursing. We know that nurses prefer leadership that is a combination of structure and consideration behaviour. Structure behaviour is characterized by setting parameters and giving direction. Consideration behaviour is focused on building relationships and providing personal support and recognition. In a rapidly changing environment, we know that leadership must be cultivated at all levels. Shared governance is essential not only to produce excellence in professional nursing practice, but also to contribute to effective executive leadership by gaining the value of the collective wisdom in nursing to advocate for the necessary structures and processes within organizations to support client-centred care. Practising nurses enact leadership through their client-centered practice, continuously advancing their professional practice through new knowledge and innovation and contributing to decisions that support professional practice settings.

**The Turbulent Environment within which Nursing  
Leadership is Practiced**

Nursing is a holistic, human science based practice. Education for nurses in the caring curriculum now focuses on knowing, being with and doing. Regardless of the curriculum, the

importance of relationship and being with clients cannot be disputed. Client complaints often centre around access to or responsiveness of the nurse, and the availability of the nurse to be present for the client. Complaints also refer to nurses dismissing the client. These issues centre around the opportunity for the nurse to be present for the client in a positive way. Nurses are asking for the same thing - the opportunity to establish a relationship and be with clients. It is within that relationship that the essence or core of nursing and caring is expressed. For some time restructuring, downsizing and prevailing business model leadership behaviours have consistently squeezed out time for nurses to be with clients, and therefore apply adequately the knowledge they bring to the relationship with clients. Unfortunately, the focus on doing and the measurement of task has threatened the very survival of professional nursing practice within health care organizations.

Work design in nursing that allows time for reflection and decision-making about one's own practice is critical in being able to honour the components of the professional work. The opportunity for nurses to have a voice in larger organizational issues, to govern their own decisions in practice and to contribute to a vision for the work in their area is necessary to support appropriate decision-making in the workplace. Nurses need support and assistance to engage and learn from the paradoxes that confront them. For example, nurses work in a medically-driven, business oriented environment focused on isolating disease and curing while attempting to bring a caring service to individual human persons. Other paradoxes encountered by nurses include the pressure to be involved in decision-making while experiencing little opportunity to voice their perspective; and the requirement to develop leadership characteristics within a work environment that does not allocate resources or time to express leadership. Work design must also reflect a knowledge of the workforce and the changing values of our younger generations of nurses, Generation X, Nexus and others, who are no longer willing to work first and play later.

### **Impact of Organizational Structure on Nursing Leadership**

The easiest thing for us to focus on and discuss among ourselves is structure and roles. It is also a source and focus of debate among us. This paper will suggest that this very debate has kept us from talking about what actually matters, which is changing our behaviours and connecting them to the context of the practice of nursing. This section will give attention to structure but we will then look at our leadership behaviour, which needs to take the focus of this paper.

Organizational structures in the new economy need to be characterized by flexibility. Words like organic, permeable, horizontal networks and vertical integration come to us from the organization development literature. These concepts are

unfamiliar in environments where militaristic, autocratic, hierarchical approaches perpetuate themselves. These approaches have arisen from the former commodity and manufacturing-driven economic environments, organizational cultures and structures.

Restructuring and a trend toward program and/or matrix management has resulted in the dismantling of traditional nursing departmental structures in many organizations. A rapid paced, complex and cash-strapped competitive culture has evolved in healthcare where leaders are required to volunteer long hours outside of a typical workday in order to meet multiple competing demands. Nurses in senior and middle leadership positions voluntarily and involuntarily turn over more frequently than in the past. Those who remain in leadership positions have minimal time and perhaps limited organizational commitment to support and mentor new leaders in learning their roles. The result is that leadership positions are not all that attractive to future leaders, and more and more it is difficult to recruit to these roles.

Program management was developed in response to the way care was coordinated and delivered. Care was often fragmented and redundant, and arose from multiple departmental silos. The move to product-line management began in the United States of America in the manufacturing economic environment. Program Management is product-line management. It is considered client-centred because services are organized around like client groups or programs. The application of this to healthcare in the United States ceased at minimal penetration of the system. We, in Canada, continue to pursue this approach in the belief that it will, by integrating all disciplines, force them to work together and to be client-centred. Yet, this is not being borne out to the degree hoped for.

Professional departments support professional standards, professional practice, quality of the discipline, education of the discipline and of students, and the promotion, conduct and application of research. The disciplines are tribal. Each discipline values the opportunity to meet together with colleagues in the discipline who provide a sounding board and support one another to do their best work as a member of that professional discipline. Historically, this valued activity has taken place within professional departments, and need not interfere with anyone participating actively and appropriately as a team member or a leader of a team consisting of many disciplines. It is possible and necessary for us to cultivate management, leadership and teamwork among the disciplines while also, simultaneously, cultivating the opportunity for them to come together within their own discipline and to share in the advancement and support of their own work.

All disciplines share the same struggle in determining how to lead their professions in our evolving organization structures. We can't go back or stay where we are. Whatever the structure, we must move to a shared leadership model. Within Nursing, we need leadership in the context of our key values and core beliefs about Nursing. We need nurses leading nurses, nurses leading nursing practice and nurses leading client-centred, interdisciplinary teams.

The shift of the executive role in Nursing to a staff role has required those nurse executive leaders to use influence rather than direct authority to advocate for client care and professional nursing practice. It is significantly more difficult to influence the allocation of resources within an organization through persuasion only. Organizations where nurse executives carry the responsibility of chief nursing officer simultaneously with the allocation of nursing operational resources, are able to maintain the linkage between the professional practice and operational activity. Nurse executives in mixed professional portfolios are caught in the paradox of needing to be seen to be 'fair' to all disciplines while still advocating for Nursing. This is also experienced where leaders are expected to be a generic manager or program leader. Integration of business and professional objectives and accountability for these objectives is required to achieve the advocacy imperative of the nurse executive role. Another paradox confronts nurse executives when business and professional objectives are not mutually inclusive.

Delaying and flattening within healthcare organizations have left the practice environment bereft of the necessary supports congruent with the requirements of practicing nurses. An examination of the kind of leadership and support nurses want and need to practice effectively and to participate in shared leadership, suggests they need access to and the support of their nurse manager and other resource roles such as clinical nurse specialists or educators. These key roles in the practice environment provide the necessary support for nurses to deal with the physical, spiritual and emotional demands of the practice of Nursing in what can be a morally and ethically distressing work environment.

### **The Process of Nursing Leadership**

Organizational cultures and climates are changing in health care. A trend toward greater involvement in decision-making is also evident. Genuine shared leadership demands a new set of leadership competencies whereby those providing direct care are the experts and those in leadership and management roles serve the direct care provider by attending to the environment and resources required to enact point of service decision-making. The former have content expertise; the latter have context expertise. In order to understand the

context of practice, nurse leaders must ask more questions than they provide answers, listen more than they speak, and enable others more than they do themselves. They must create networks and relationships and promote synergy through the energy created by the relationships. Both context and content knowledge is critical to ensure that quality patient/client care is achieved. Hence, the "leader as hero" notion is no longer relevant or appropriate. The concept of servant leadership is useful in this context.

Meg Wheatley talks about the power that is realized in the development of critical connections versus critical mass. She talks of the role of leaders in building cities of people who are relationship-based (Wheatley, 1991). The application of her work in relation to nursing leadership is very useful and can apply to any nurse in any situation.

Nursing leadership behaviour must be about saying 'yes' and taking risks. It needs to have the potential to develop the kind of shared leadership capable of drawing on the contribution of every professional nurse within a nursing division and an organization. Nurse leaders at every level need the opportunity to have voice. They need to participate in the development of a common vision in their workplace that supports a loose/tight approach to providing both the structure and consideration behaviours necessary to support the unique or autonomous professional practice of nurses. Research examining that style of leadership suggests that consideration behaviour is necessary to facilitate the ability of nurses to be autonomous or to make decisions about their own practice.

Leadership behaviours that support autonomous professional practice must include the following:

1. Support on a one-to-one level for nurses working through issues related to their practice and providing a sounding board to them when needed.
2. Recognition of the value and excellence of nurses.
3. Expectation that nurses will exercise direct decision-making authority and accountability for their work.
4. Provision of the opportunity for nurses to have input and give feedback into larger decisions related to the workplace that affect nurses' professional work.
5. Provision of opportunities for nurses to participate in establishing a vision within their workplace about the kind of work that they wish to do and how they will work together to bring alive their desired future.
6. A holistic approach to nurses, understanding that they are persons within the context of a family and community who have a larger personal life, human interests, needs, hopes and dreams. (Ferguson-Paré, 1998).

Executive leadership behaviour needs to foster shared leadership behaviour within the professional nursing work. Leaders must acknowledge and see nurses as knowledgeable workers. They must establish environments that foster and facilitate collaboration within an interdisciplinary team environment where the unique practice of nursing; the knowing, being and doing of nursing; is conveyed with pride by each professional practitioner and supported by the leader in their workplace.

Nurse leaders are moral agents at every level of the organization, and have a huge advocacy imperative on behalf of their fellow professionals and those they serve: our clients/patients/residents and their families. Nurse leaders must identify the ethical issues, translate distress where needed, name issues, support and enact leadership and a vision for ethical practice. This is knowing the context as well as the content. Enacting moral leadership requires initiating change in healthcare environments. On an interpersonal level, it is necessary to listen to nurses and their stories of practice in order to make structural changes and bring their voice to the political platform to help nurses to move forward. Moral leadership is expected of nurses, and resides within the paradox evident in business-dominated organizational cultures today, where nurses are experiencing little organizational support to face the moral and ethical dilemmas they may encounter.

The absence or presence of nurse leaders makes a difference. Providing leadership in the context of professional nursing practice means that we need to restore humanism to the work environment to help nurses feel safe, respected and valued. Nurse executive leaders are needed to manage and lead in the reality and the humanity of nursing practice. These leaders invest in and support baccalaureate as entry to practice for nursing and continuing education to support nurses in their professional work. These leaders invest in the needed hours of care required by clients, understanding the connection to emotional exhaustion reported in the international study conducted in five countries including 17,000 nurses from Ontario, Alberta and British Columbia in Canada (Aiken, et al., 2001). Early reports from this study indicate that emotional exhaustion leads to poor quality of work life outcomes for nurses, and negative quality of care outcomes for clients. These nursing leaders unleash the power of nursing by supporting nurses to speak up and speak out about their relationship with clients and their perspectives on the healthcare system. There is an important link between ethics and power. These linkages live through the nurse executive leader.

Nursing is a profession that the public knows about on some level and is generally trusted. It is strategic and appropriate to consider how to further align the profession with the

public from a positive perspective. For example, the development of a more public philanthropic perspective based on the caring work of the profession would enhance public support for Nursing. At the same time, we can dispel some of the myths and stereotypes held of nurses, leading to the perception of a lack of knowledge or scientific base for the profession. Wheatley talks about building a culture that is alert to what is happening around us and gathering information from multiple sources in order to continue to grow and generate new capacities (Wheatley, 1991). Tim Porter-O'Grady builds on this work, giving multiple examples in his texts about moving from the industrial to the knowledge age (Porter-O'Grady, 1992, 1997, 1999).

Since nurses represent the vast majority of health care professionals in teaching hospitals, there is a compelling need to ensure that a nurse and a nursing voice, are represented in key places in the organization. These key places include the senior leadership, Board, and Quality and Inter-professional structures, in addition to leadership within programmatic and/or clinical groupings.

### Summary

We see nursing leadership existing at all levels in nursing... all nurses leading. Nurse executives within academic health environments across Canada will be influencing health policy directions and dialogue within the profession nationally. They will be contributing to the development of a national agenda for nursing practice, education, research and leadership. These nurse executives will lead in a way that makes an invigorating impact on human service in health care environments and they will be dedicated to preparing the nursing leaders of tomorrow.

The Academy of Canadian Executive Nurses will connect with the Office of Nursing Policy, Canadian Nurses Association, Canadian Association of University Schools of Nursing, Association of Canadian Academic Health Care Organizations and others to develop position papers regarding key issues such as patient safety, health human resource planning and leadership in the Canadian health care system. Our definition of professional nursing practice, fully integrated with education and research, will be advanced through these endeavours. The end result of a strong individual and collective voice will be improved patient outcomes supported by professional nursing practice in positive practice environments.

This paper is intended to stimulate dialogue among nursing leaders in Canada, dislodge us from a long and traditional path, and place us firmly in a new millennium of leadership for the profession and practice of nursing, a style of leadership that is needed, wanted and supported by nurses and the clients we serve. It is the responsibility of those of us who

lead in academic health science centres to be courageous for the students we support, the practitioners we lead and the renewal of the profession. We are the testing ground for nursing research, and need to be the source of innovation for nursing practice. It is incumbent on us to leap forward to engage a new vision of the professional practice of nursing with a reconfigured work design and work environment compatible with the new economy, workplace and workforce.

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