Interview with Kathleen MacMillan, Former Provincial Chief Nursing Officer

Career milestones are natural points of reflection. They can provoke us to pause, think about the contributions of colleagues and perhaps glean bits of wisdom from the life lessons they learned on their leadership journeys. Michael Villeneuve recently sat down with his friend and colleague, Dr. Kathleen MacMillan, to reflect on her views of nursing and healthcare as she transitions into retirement from the full-time phase of her nursing career.

[IN = Interviewer (Michael Villeneuve); KM = Kathleen MacMillan]

IN: Kathleen, you've had a distinguished and highly visible leadership career in nursing. Let me take you back to the beginning: did you plan this career, and was it your first choice?

KM: When I was growing up, women had three choices: secretary, nurse or teacher – and I didn't like the other two. I grew up thinking, "That is what I am going to do." I was exposed to the "Jean Hunter" series of children's novels from the UK – *Jean Becomes a Nurse* – and I have to say that really did influence my thinking about nursing. My parents didn't pressure me into traditional roles; they were both very encouraging, so that wasn't an issue. Of course, I thought about medicine; at some point I think any smart individual who's interested in healthcare entertains that notion, but I didn't take it very far. I did do a master's in anthropology, but ultimately couldn't see myself in that career. So I went back to nursing and did a graduate degree in nursing after that.

IN: Do you feel that graduate education in nursing is the right route for nurses to take? In the end, was it right for you?

KM: Yes to both. Initially, when I went back to university after doing my nursing diploma, I went to do a degree in science, because at the time you had to go full-time to nursing school and that was difficult for me to organize. So I did my undergrad in science and took an introductory course in anthropology, and I went straight on and did a master's in anthropology. For a while, I did some clinical teaching, though I was always conscious that I didn't have the nursing credentials. That's what led me to do the master's in nursing. That was important to me; I felt like I was legitimately a nurse with a graduate education who could be a clinical teacher. The social science background was a big advantage, though, because it gave me a broader perspective.

IN: When did you start to see yourself as a leader? How did the call to leadership unfold for you?

KM: I always say I became a leader by accident. I think probably the first time I really felt I was in a leadership role was after I took a position as a clinical teacher at Mount Sinai in the 1980s some 15 years into my career. That particular environment was very conducive to developing leadership capacity. The other big thing for me was joining the RNAO Board of Directors. I see getting involved in the professional association as a key development opportunity. I moved on to become president and that, of course, takes you into a whole different realm of exposure to leaders and leadership.

I wouldn't have called myself a leader up until I had that formal title. I often was encouraged by others, by mentors or people who saw potential in me that I didn't necessarily see. That impressed me, and as a result I try to make a point of identifying people who have potential. Most of my mentors were women, given the profession, but I've always tried to identify people who are not like me – to reach out to those from different cultural backgrounds, to males, or different ethnic backgrounds – because people, when they do identify potential in others, tend to connect with people like themselves.

IN: Kathleen, with respect to your policy leadership experiences, please tell our readers about the lessons you learned in your role as Ontario's first provincial chief nursing officer, and then leading the Office of Nursing Services in Health Canada's First Nations and Inuit Health Branch. What worked, and what would you do differently?

KM: Before taking on the role in Ontario, my first impression was that the government was largely an evidence-free zone. Many decisions are made on the basis of ideology or potential to garner votes or support, or trade-offs and negotiations. Evidence certainly is not the prime driver of decision-making; there's a lot of

compromise. I had to learn some skills around pragmatism and what's possible, particularly with regard to timing. It's often being in the right place at the right time with the right supports that makes things possible. But that said, I still think a lot of my success came from basing policy advice on evidence. I think that was probably where I was able to make persuasive arguments about one choice over another.

IN: John Maynard Keynes once said, "There's nothing governments hate more than to be well informed."

KM: I think that's true. And those who take a populist approach to government in the interest of re-election are playing a very short game. Others don't want to do anything too different because it's hard and may not please some segments of the population. Doing nothing is a policy too. What's more, the BScN entry to practice was disruptive to the status quo and cost money – both things governments don't like.

But if you are a statesman in the true sense, your focus is on the long game; a vision of where you want the country to go and to build something greater than yourself. Then you need reliable data to avoid unintended consequences of policy.

The genius of democratic government is that there are logical tensions between the bureaucracy and the elected government – especially when new in power – that tend to result in careful and considered change. Nursing has to figure out how to ride between those two forces strategically.

Over time I developed a reputation for being credible – for not being partisan or ideological, but just factual. A lot of that I owe to the Nursing and Health Services Research Unit, where Linda O'Brien-Pallas and Andrea Baumann were building evidence for nursing practice. Initially, that approach was not viewed positively, but you just plug away at it. I think it's important to be very measured and soft-spoken. If someone makes an outrageous comment, just say, "Well, that's an interesting perspective but the evidence wouldn't bear that out." Those quiet statements help you to be seen as factual and credible. I think building that reputation over time was effective.

The federal job was different in its orientation because the federal government is essentially a policy shop. First Nations and Inuit Health Branch was an anomaly, because they do deliver services. But I think the Branch felt the government didn't really understand that their responsibilities were probably more like provincial ministries of health – for example, the need to respond quickly within a policy framework was often challenging. I saw the policy and operational challenges of trying to respond to regional and cultural differences in values and opinions; First Nations peoples are not homogenous! And I have to say I saw a strong commitment on the part of the bureaucrats, and of Canadians in general, to the welfare

of Aboriginal people and Aboriginal communities. I definitely felt a desire to do good things to escape that traditional colonial model, and empowering Aboriginal communities and peoples to have self-determination. This work was not always successful, because there are always barriers to implementing those kinds of changes; but overall, I thought the motives were good.

What would I do differently? I think there were times when I could have built coalitions more effectively. Sometimes I got a sense of urgency or timing around issues that I felt didn't lend themselves to taking time to build cooperation. Sometimes you just had to push ahead.

The degree entry to practice in Ontario was one of those issues where barriers arose periodically because nursing wasn't all together. There were times when I would bulldoze through on some decisions just because there wasn't the time to do the background work that you need to do. I was working hand in glove with the nursing associations and organizations and the Research Unit in a collaborative team with the College of Nurses.

On the degree entry-to-practice issue, some bureaucrats said this was groundbreaking and revolutionary thinking that required a lot of analysis. Then I would point out that the Weir Report had made this recommendation in 1933, and perhaps 66 years of sitting on it was enough.

IN: You are leaving the formal part of your career in the role of a dean of health sciences. What concerns you with regard to nursing education?

KM: Well, first, let's acknowledge the gender issue. The healthcare system was set up like a patriarchy; you had the male physicians who were papa and you had the nurse executive who was mother, and everybody else were the children; and you were just supposed to be obedient and follow orders. Nobody saw the need for an educated nurse. That goes back to the mid-1800s, when Nightingale was trying to develop nursing education, and later to Isabel Hampton-Robb, who fought for appropriate education and for "trained nurses" to deliver care at Johns Hopkins. But really, the issue was about how much education you could possibly need to do women's work. "Doesn't that come with the X chromosome?" I think that was most of the argument. At the time I heard a politician say very clearly that if this had been a man's profession it would have been degree prepared a long time ago.

The entrenched power of the medical organizations and hospitals was another force. The hospitals were always afraid of having to pay for nursing services – recall that when I started nursing school in the '60s, many hospitals were still using students for much of the nursing care.

Am I happy with the outcome? I am. To realize the benefit of moving the healthcare system away from an illness model to a health model, and health promotion and evidence-based practice or evidence-informed practice – as it's being called now – we must have better educated nurses. They must able to take their place on a health-care team. This was an essential move in order to reform the healthcare system.

Is it getting there as fast as I'd like? No. In some ways, I feel like the current generation is a bit of a lost generation, because we're turning out nurses who are ready for a different kind of practice; but practice is lagging, and we're wasting intellectual capital. The naysayers will say, "Well, they didn't need to be that well educated in the first place," but that's not true. We know that patients are not happy with the assembly-line care they're getting in the healthcare system right now. Most of the time we're still focused on a medical model of care. If somebody goes in for a procedure and they survive and they don't have any iatrogenic complications, we don't care if they suffered, if in the process their psyches were damaged, they felt de-personalized and dehumanized – that doesn't seem to matter right now.

IN: Why do you think nurses let it go on? There are 263,000 of us in Canada; we're the largest segment of the healthcare system. Why can't we, or don't we, change that model if we know it's wrong?

KM: The vast majority of care providers have been in the system for 35 or 40 years, and they have been the victims of all of the reforms and reorganizations and restructurings and layoffs. They're totally fried. We have a whole cohort of people who are doing a physically demanding job and they're now pushing 60. I think they're just worn out and are still working at such a fast pace. The system does not reward caring. The system is about getting that care map accomplished and making sure nobody deviates from it. It's about efficiency and effectiveness, designed on a purely physiological survival model. Who rewards a nurse who really cares about the patient, who really wants to get to know the patient and know what's important about them? There's nothing in the system that rewards or recognizes this thinking. It takes time, and time is money. The danger here is that the younger generation of nurses who do want more are not likely to stay – particularly in the acute care setting, because it's not rewarding. Nobody wants to come home at the end of a shift and rhyme off that they gave out 150 medications and changed 25 dressings and made 15 beds. That's not what we went into nursing for. It's a 19th-century model of practice and a 20th-century model of education, yet we're asking nurses to function in the 21st century.

There has been some leadership in medicine towards getting back to its roots in a therapeutic relationship with the client. Physicians have a more direct relationship with the client, in many ways, than nursing does. It's clear to them who they're

accountable to, whereas for nursing there's this fuzziness about accountability to the employer as well as to the client. Medicine has made some enormous strides in this area, and nursing is being left behind. It's something we need to pay attention to, and it's linked to basic patient safety.

One of the things that I think nurse leaders don't do enough of is listen to front-line nurses. It's like NASA's experience with the *Challenger* disaster. After the fact, NASA analyzed what happened, and the front-line engineers had a much more accurate perception of the risk of those O-rings failing than the decision-makers at the top. When you get into that issue of boundaries of safety, the people who know best are the ones at the front line, but they're also the ones who are often cutting corners to meet efficiency requirements. They know best how much risk there is, but they're often not listened to.

You can't blame nurse leaders, because their span of control is absolutely crazy. There's no business in the world that would say you have one leader for 120 people and be expected to not only manage the business line but also mentor and support professional practice and quality assurance; it's an impossible task.

IN: Before we leave education, a series of major reports in Canada and the United States has called for radical reform of nursing and nursing education. What are your reflections on this?

KM: Unlike medicine, we still have not figured out how to bridge the gap between academia and practice. Ever since nursing came out of the hospital schools, nurses haven't had the same commitment to their role in educating nurses. And government never recognized the true cost of clinical education for nurses and other healthcare providers. The issue of clinical education requires a national taskforce on how we might do it differently and better, instead of just adding more funds to do the same thing. I'm not convinced that students are getting experience that relates to the curriculum or that teaches them best practices. In many cases, they're being mentored and exposed to nurses who, as I said, are tired and who see limits rather than possibilities.

The other thing that I see, in Ontario anyway, is a diverse student body. Historically, a nursing school was a homogenous culture with shared values. What we lack now is time to teach in that affective domain about Western bioethics models and what we think is important in terms of accountability and professionalism. Time is even more of a crunch in the shorter practical nursing diploma programs. Across both programs, I'm seeing issues that concern me related to self-regulation, accountability and responsibility in some sectors of the population who choose to go into nursing.

Patricia Benner's study for the Carnegie Foundation talks about the need to teach "moral and clinical imagination." Students should be exposed to possibilities. If we can't come up with better strategies for teaching in that affective domain, I think that's where we may lose the next generation – because we've always assumed women came with that affective domain attribute. But they experience difficulties with moral integrity and feel regret because they aren't well prepared in bioethics, or they feel powerless. Some students come with fixed ideas of women's roles that influence their ability to advocate for clients and for the profession. We now have such a heterogeneous population of students that we have to turn our attention to how we teach these things. It's not just socialization. Benner talks about taking on that mantle of the profession and what that means in terms of moving away from a focus on yourself to a focus on the client; a difficult task. But I do think that's going to come.

We also need a formal framework for entry to practice in specialty areas that require additional education. There is enormous regional variability in requirements for these settings, and a national taskforce could take this on.

IN: What are your observations of the impacts of technology?

KM: So far it hasn't done much for nursing. Nursing has prided itself on being low tech and has not embraced all that technology can do. We still have hospitals that think if nurses walk around with a Blackberry or an iPod, every electric device in the hospital will go rangy. Some hospitals have signs that you can't use your cellphone. As you've often said, Mike, the first place our younger generation of nurses will see carbon paper is when they go into an acute care facility. We're still very 1970s in some ways, not embracing technology. The Robert Wood Johnson study pointed out that nurses in a medical–surgical unit walk, on average, 10 miles in a shift. What a waste of time and intellectual capital! Why not bring the technology to the nurse? We really need to redesign our whole approach to technology to reduce physical labour. We're a long way from that. I hope the younger generation is going to come in and say, "Are you out of your mind? Are you telling me I can't use the computer to Google information for my client? Do we really have only one computer terminal on this unit for all these nurses?" Part of the problem is a patriarchal perception that allowing nurses access to technology at work will mean they'll spend all their time on the computer. I've heard people say that, which is ridiculous.

We haven't begun to mine the potential of online healthcare. Why should you sit in Emergency for six hours? Why can't you email ahead for an appointment and appear at an approximate time when someone is able to see you, so you're in an electronic queue instead of sitting in the ED? Why can't you Skype a healthcare professional to have them look at your rash or your wound and then e-mail a prescription to a drugstore for you to pick up – complete decision-making

support online. I can't believe we're still teaching nursing students how to describe a wound verbally instead of just taking a picture of it.

IN: Turning back to your policy leadership, what was the most interesting policy experience of your career?
KM: There were two. One was the Nurse Practitioner Initiative in Ontario and the other was the Baccalaureate Entry to Practice. I was really fortunate to be brought into government when much of the NP policy work that was started by Dorothy Hall had begun to be implemented. I was part of the legislation. I remember being on the floor of the House when it was passed by all-party agreement, which was an amazing experience. And I moved from working in the bureaucracy to working in the political staff. Again, two very different kinds of roles. I always say the best education I ever got without paying tuition was working in government; just understanding how it works and what strategies you need to be able to communicate with politicians. I feel uniquely privileged to have had that opportunity. It was purely luck and timing, and I will always be grateful for it.

IN: You cast a wide sphere of influence on people who have looked up to you, learned from you and want to emulate you. As you reflect back on a brilliant career, what are your personal reflections on the people who influenced you?
KM: The first person who influenced me as a nurse was Jean Campbell, the public health nurse at Agincourt Collegiate when I was a high-school student. Jean was an absolute role model of what a nurse should be, a school nurse who was just amazing in terms of working with the students – she was revered, in fact. I went to the Toronto East General nursing school because that was where she had gone. I can still see her in her lab coat. When people had a problem, they would beat a path to talk to Jean. She was a terrific person.

When I was a clinical nurse, sometimes I'd notice a colleague who did something really well and I would say, "Okay, I want to be able to replicate that" – for example, how somebody communicated with a patient. So I was always observing others and trying to figure out what I could learn from them. Professionally, I would say that Judith Shamian has been an enormous influence on me. She's politically as well as professionally wise. I would say her passion for nursing has shaped me in lots of ways.

IN: Now that you are retiring, what advice would you give to a prospective or novice nurse who is running into some of those roadblocks you've talked about?
KM: Find mentors. No one person can be everything to another. You need to be deliberate about finding that person who will take you on and mentor you. I wouldn't be where I am today without such people.

Be courageous. I'm thinking of Joy Richards's doctoral study on courage in nursing. When you're in a leadership role, be prepared to be fired, be prepared to not fit, be prepared to be in a position where others don't agree with you. Be prepared to move on when this is not the right place for you. There are times when you're going to have to ask yourself, "Is it my principles or my employment?" So courage is important.

Don't stay too long in one place, because you get stale. I've tended to move every three to five years. It takes about five to seven years to make a cultural change in an organization. Sometimes you need to stay long enough to do that, but I wouldn't recommend staying past that. I think you need to pass the ball to somebody else to keep the momentum going, so you don't get into a comfortable place where you don't think other things need to be done.

Have a researcher that you talk to. Have a group of colleagues that you talk to, because we all need perspective. Sometimes you think you're right, but then you talk to other people and you realize maybe you weren't. Surround yourself with people who don't agree with you, because it keeps you on your toes; it keeps you honest.

If you're not making at least some people mad, you're not doing anything. You can't make changes and keep everybody happy.

I must say that despite the barriers, I feel very hopeful about the next generation of nurses. I think our nurse leaders, no matter where they are, are often doing the best they can in circumstances that are very difficult. We owe a debt of gratitude to people who get up every day and stay committed to whatever it is that they're trying to do under difficult conditions. I think that the next generation is going to support the leadership in a way that past nurses have not. They're a different breed; they're not about to be victimized or dismissed. If the healthcare system doesn't change, they're going to vote with their feet. I think that their courage will instill some courage in the leadership, and will support them in a way that they probably have not been supported in the past.

Some of our students remind me of the 1960s generation; they have a sense that they can and will make a difference in the world. They're very global in their orientation. They really do want to make a difference, and for that reason I am hopeful. I'd better be, because I'm probably going to be a healthcare consumer at some point, and I hope that they have had an opportunity to influence the system before I'm 80! So this is my time to move out of their way and give the next generation the chance to flourish and lead. Some of us need to relegate ourselves to the cheering section for a while and give others some opportunities.