Of Hubris and Hope: Transforming Nursing For a New Age

Executive Summary

- Changes in technology and the related expectations of patients are primary drivers affecting the future role of the nurse.
- The significance of the ongoing forces that will change health care delivery is outlined in this article in the context of the inherent challenges facing the nurse leader.
- The key role of a nurse leader in the fray of these changes and through the future will be as a “signpost reader.”
- In many cases, managers are realizing changes as they are occurring, so time that was used to prepare, experience, and adjust to change is significantly condensed, requiring totally different leadership skills.
- The author emphasizes the need to identify and let go of traditions and standards that had meaning in a delivery model that emphasized “hospital-based, sickness-oriented, late-stage” care.
- Since the “Age of Change” will bring a continuous need for adaptation, nursing leaders will need to identify short-term achievements, celebrate and refuel, and move toward the next wave of transformation.
- Awareness of cultural norms remains paramount in effecting and sustaining meaningful change.

In every arena of nursing practice the vagaries of a new century are wreaking havoc. What is especially painful is this is just the beginning. The course of change brings with it its own rules of process and calls leaders to be aware of how change really works and its impact on the very experience of life.

Change Is

The physics of quantum mechanics has taught us that change is not a thing or an event; it is instead a dynamic, the major element of a universe that is still unfolding (Gryskiewicz, 1999). Change is the major motivator of life and movement in the universe. People have no control over the condition of change but do influence its circumstances and actions. In short, people don’t make change they simply give it form. Change is not something we define; it is more something we discern (Zimmerman, Lindberg, & Plsek, 1998). The direction change takes, its application in human experience, and its impact are what humans can influence and affect.

Schroedinger, a famous middle 20th century physicist, proved with his famous “Schroedinger’s Box” analogy that there are two prevailing realities that operate at any given time: actual reality and potential reality (Zohar & Marshall, 1997). The former is the reality that currently occupies our immediate experience and moments; the reality in which our senses and awareness are presently engaged. Potential reality, on the other hand, is current and present to us at any given moment but, while present, is not yet experienced. Potential reality is inevitable and just as current and applicable as actual reality; it is just not yet experienced. Until applied, it is still potential; present but waiting for the right moment of its expression when it will then become actual much like a stop sign in the street can be seen long before it is responded to by a driver (see Figure 1).

It is in this arena of potential reality that leadership takes its form. The leader is differentiated from the follower in that the leader derives the preponderance of his or her role within the scope of potential reality. It is the leader’s role to engage unfolding reality in advance of others experiencing it; to see it, note its demands and implications, translate it for others, and then guide others into process-

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es that will act in concert with the demands of a reality that is not yet present but inexorably and continuously becoming (Blanchard, Carlos, & Randolph, 1996).

In this transformational time in healthcare here at the outset of the 21st century, the primary role of the clinical leader is to live fully aware of the unfolding potential of this journey. It is the skill sets of awareness, availability, and anticipation which now most defines the character of clinical leadership and calls the leader’s understanding of the application of the role into a new arena for it. Today’s nurse leader is not so much merely an operational expert and problem solver, but is in addition, a good “signpost reader.” Standing on the balcony in the journey of change, the good leader can see and anticipate the direction and path of change and then translate it well to those who are moving their own activities knowingly or unknowingly in the direction the change is moving them (Buckingham & Coffman, 2000).

**The Age Change**

It is challenging for the clinical practitioner to live in the chaos of the transition from one age to another. All of the dynamics of a substantive and transformative change are moving in concert to create the underpinnings of a comprehensive transition from one way of living (social reality) to another. This has occurred several times in human history and is noted in the western world by defined demarcations of time. From the Middle Ages to the Age of the Enlightenment, through the Industrial Age to the current Technology Age, there are historic indicators of major shifts in the human experience (Oliver, 2000). When looked at far enough from the critical moment of such transition, it is clear just how significant these age changes were. However, when a person is actually living through a period of shift, the content, meaning, and the value of age-driven differences is not always as readily apparent.

Still, when the specific changes are enumerated, it doesn’t take long for the participants to realize how important the time is for them and those who will follow. Indeed, even the agents of change soon realize that even they are personally challenged by the change. In this process there is often no time to predict distant future changes and then wait for the far-off moment to arrive before having to confront its unfolding reality. Instead, in an age change, the predicted changes are occurring at the same time they are being experienced, leaving little time to discuss, plan, and accommodate them. In our time we are already living much of the science fiction we were reading only a decade ago (Beer & Nohria, 2000). The pace of technical and social transformation is literally that fast.

The challenge for today’s clinician is the realization that he or she doesn’t have the luxury of time to adapt to the changes they are seeing. Like everyone else, providers are now forced to incorporate the application of change before they have had time to adjust to the impact of the change. We are often implementing the changes at just about the same time as we are seeing them. Whole different leadership skills are required to manage in this kind of a world.

Imagine just for a moment a small sample of the drama of technology as it serves to force a rewrite of the script of human life. Consider the following:

- The Internet is the fastest growing primary business tool of the time, shifting much of how information is managed to an entirely different formula for its application. It is predicted it will be the primary source of reference, education, and application within the next 2 decades.
- Fiber optics has connected the world together in a seamless communication network that transmits instantly from one end of the world to the other. In conjunction with satellite technology, there is no place on the globe where one cannot communicate with another place in an instant in time. It is anticipated that mobile communication devices will change the nature of work and clinical practice to enable the clinician to be visually connected to others at any time and place. Through the fiber-optic network for example, surgery done in one city can be “experienced” in another; location is no longer an impediment.
- Access is highly portable allowing consumers to get anything they want or need anywhere in the world with corollary shipping and transporting capabilities. It is expected this will alter the consumers’ health service demands to match the same expectations they have with other “just-in-time” services.
- The consumer/user now has control over almost any relationship, whether personal or business, and now can personalize any interaction within any context he or she provides at any time and in any way. The consumer is not concerned with what nurses have to give them, rather they are interested in what they get from nurses (from a process orientation to
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Leading Change

It is unimaginable to conceive that there is anyone today who does not know that we are in the midst of major social transformation. Reticence to move into a new model of clinical care and service delivery that is mobile, fast-paced, consumer (user) driven, and non-institutional is no longer optional. Practices that limit or preclude clinician's response to this new reality are now threatening professional relevance and viability.

The nurse leader's role is to encourage if not push this movement into a new lived reality. Indeed the clinical leader must exemplify in her or his life both a commitment to the journey and a concerted effort to struggle with incorporating the new demands in life in a very personal way. No longer can the leader simply suggest that everyone and everything must change. Instead, the clinical leader must be able to exemplify the change at a personal level within her or his own behavior and role expression with all the noise and pain associated with this new journey. Today's nurse serves as a witness, even template to the change, both required to best represent the change to those the leader directs and who must ultimately experience it in their own lives.

Passionate Commitment to Change

At the initial level of change the clinical leader must be able to represent the criticalness of the change with a passion for movement that inspires and requires response. There is no room for complacency in this next phase of
the journey. It is a time of truth and confrontation. In short, it is a time to make sure those whom the leader guides on the journey know just how significant the change is in their lives and in their work. This truth-telling requires a level of honesty and directness once thought to be confrontive and challenging. The journey is so critical that complacency in its taking is no longer appropriate.

This is the beginning of the end of nursing care as we have all become accustomed to providing and using it. The hospital-based, sickness-oriented, late-stage model of nursing service delivery is no longer either appropriate or prevailing. Nurses now must determine what traditional practices and functions are no longer relevant or sustainable and let them go. At the same time, nurses must discern what is emerging on the practice horizon that must now become increasingly a part of nursing practice. Influences like genomics, nano-therapy, fiberoptics, pharmacotherapeutics, virtual care models, early-stage interventions, patient managed delivery, etc. are now pressing on the periphery of the profession and will dominate nursing adaptation for the next 2 decades. The technology of the time is quickly moving the health professions into a context where the kind of therapies that will be used require less mechanical and manual intervention and a greater use of other innovative approaches. This transition makes it possible to treat illness at an earlier stage and either eliminate or alter the need for more mechanical (surgical) interventions that are more intensive and costly. It is quickly becoming a time of ending for the health care system as we know it. Furthermore, it is the end of Newtonian, 20th century medical and nursing practice and other health-related practices as those disciplines have historically understood them (Schwartz, 1998).

The work of the time for the clinical leader is helping colleagues and patients end their attachment to the kind of health care system they have grown comfortable with. So many nurses are mourning the loss of something they think should not have passed or should be retained. Many nurses are mourning the loss of those very practices, sentiments, or roles that brought them to nursing in the first place. Some even wish those traditions would return. The truth is that most of what is being mourned should neither be retained nor protected. Neither the times nor yesterday’s circumstances will return, nor should they. That was then; this is now. Those ideals that brought many of us to nursing (enough time for good care, long stays, detailed care processes, residential models of care, heavy emphasis on manual procedures, compliant and passive patient roles, etc.) no longer exist. The question is not will these processes return but instead: what is nursing now becoming and how must I adapt (Fulmer, 2000)?

**Engaging the New Reality**

A major role of the clinical leader in this day and time is engaging others around the reality of their own change. Complacency at this time of radical shifting is a strategy that guarantees failure. The leader must take whatever action is necessary to impress upon those he or she leads that this is a time of great mobility and shifting foundations (Heifetz & Laurie, 2001). It is a time that is calling the stakeholders to the table to work out what must be altered and reintroduced in a new context for health service. It is a time to embrace and engage not to simply stop and watch or lament the passing of an age. The greatest tragedy of the time is the nurse’s failure to engage the demand for change in clinical practice at the right time, leaving nurses to simply react to these demands too long after their emergence.

Leaders too may be victims of their own perspectives. Too much dependence on past successes creates a definition for success which may no longer be sustainable. The greatest impediment to future success is past success (Argyris, 1999). Whatever defines the contextual framework of success in the past can be temptingly easy to use as the measure of current success, resulting in the wrong measure for the right issue (staffing ratios, more staff, keeping patients longer, more money, etc.). Clinical leaders must see the approaching challenges within the context of their becoming, not through the eyes of past experience, old solutions, and historical triumphs.

**New Foundations for the Future of Practice**

Closing the door on a passing age is only half the work. The leader must now turn around from the closing door and directly face the emerging future. Doing so requires vision from the nurse and more importantly, having the right vision. There is much in the unfolding landscape that begs for great vision. One of the problems with nursing leaders is that their vision can often be too tenuous and shortsighted. The conditions for the future of health care are tremendously and vastly different from anything that has been experienced to date. The landscape now calls clinical leaders to have an entirely different and significantly radical vision of how we will live in it. The impact of micronization, genomics, chemotherapeutics, phar-
macology, biotherapeutics, etc. is forever altering the foundations of western medicine and nursing practice (Clippinger, 1999). The manual and mechanical dominance over medical practice throughout the 20th century is inexorably giving way to the bio, geno, chemo, techno, and pharmo-therapeutics of the 21st century with all that this implies. The organizing and supportive infrastructure for the emerging models of therapy demand confronting and deconstructing many of the institutions and structures of 20th century medicine. It is no wonder that the structure and infrastructures which will support these new therapeutic underpinnings will need new visioning. Much of the existing bricks and mortar as well as the administrative and operational frameworks which are current in hospitals and health services are continuously less relevant including the policy, regulation, and certifications that support them. These are now constantly and continuously being challenged financially, politically, and technologically. Many elements of traditional health service must now be adjusted or even eliminated. Imagine for just a moment how painful this message of deconstruction and reformatting is to the serious and talented men and women who devoted their lives to building the current health system infrastructure. Think also about the many nursing heroes who have fought to build the current foundations for nursing practice. The challenge confronting the requirement to tear practice apart and examine care practices anew is all but overwhelming. This, however, is what the vision of creating a new and pertinent future infrastructure calls nurses to do and is now the major work of the time.

Communicating a New Vision

The clinical leader must be able to communicate this new vision successfully. She or he brings as much energy and commitment to deconstruction and new construction in nursing practice as is possible (Beckham, 1994). It is time to capture the minds and hearts of all in the health care system in the effort to assure it is well led into a preferred future. This requires that nurse leaders be relentless communicators, forever challenging traditional thinking and doing. The contemporary clinical leader is forever pushing the walls of thought and the work of those she/he leads to assure that the stakeholders are fully engaged in challenging what they currently do, are looking at the value of their work, are asking questions about the congruence between what they are currently doing, and the changing demand for it (Chaleff, 1995). In short, today’s leader makes it safe to question, to risk, to stretch staff into new ways of thinking and being congruent with the opportunities and emerging demands of transforming clinical practice.

The nurse must be aware that assessing the appropriateness of all current rituals and routines of practice is the work of the time. Value now demands that everyone examine his or her efforts closely and collectively to determine what should be retained and what should legitimately be left behind because it is no longer appropriate. The nurse leader creates the angst and the demand, further pushing the walls of clinical practice and product, and raising questions regarding efficacy and effectiveness when practice is examined within the context of a new and emerging set of demands and expectations.

The most important expectation is to communicate vision and change, not so much in the words that are said but more by the lives that are changed. The nurse leader must exemplify in her or his own behavior the application of the changes as a lived experience. If the clinical leader cannot live the demand for change in his or her own experience, it will be impossible for others influenced by this person to do so in their own lives (Christensen, Bohmer, & Kenagy, 2000).

Anticipating Tomorrow

The next most important factor in successful change is the ability to anticipate and identify the roadblocks to substantive and successful change. Every change requires integrating numerous activities and people. As a result, there are many imbedded obstacles to implementing change successfully. Most notable are elements of the prevailing organizational structure which itself acts as an insulation from the demand for change. Some of the first activities of change agents are exemplified in diffusing the power of structure in the organization, removing the prevailing barriers to concerted and dramatic action on the part of the stakeholder.

The wise agent of change must know at the outset that there are people who have devoted their lives to preserving and assuring that change does not operate in their lives and, by reflection, in the lives of anyone around them (Greenleaf, 1998). These people are often addicted to negation. However, one blocking person can bring the entire change process to a grinding halt. The leader must name, identify, challenge, work with, and, if necessary, shift people who can’t adapt. Staff must be empowered and inculcated in the process of their own transformation so they do not themselves become stuck in effectively fore-
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...stalling what is necessary to assure the organization thrives in its new reality. Group barrier identification and strategic efforts to address them is a critical first stage in engaging staff in meaningful change.

The long-term nature of an age change creates the need to identify and achieve short-term gains. People must perceive movement and accomplishment. It is important for the leader to identify the short-term gains that help nurses enumerate their effort in the journey to a new place. This allows for demarcations in the process of change to be visualized in a way that can be celebrated and acknowledged by all. It gives a moment of respite and reflection and helps people gather energy necessary for the next stage of effort, moving inexorably toward a more congruent and viable place to live and work.

The clinical leader must look at change as a journey not an event (Kawasaki, 1999). It is premature to claim victory or arrival. Every arrival point is also a debarking point. There really is no permanent point of respite from change. Since everything in life is a journey, it is important for the nurse leader to keep an honest perspective. The arrival points are merely points of demarcation, of momentary rest. The wise clinical leader carefully balances the moments of rest and celebration with those of effort and action. Depending upon the demand, the timeframe, and the circumstances, leaders choose the moments of marking success carefully so that they can serve to reenergize when necessary, refresh when possible, and challenge when appropriate.

Finally, change is a cultural experience just as it is a personal one. Culture always rules. This truth must be solidly imbedded in the mind of the clinical leader as he or she works change in the organization. Change must somehow enhance or improve the work or the workplace. Today’s nurses are not faithful to the workplace. They are, instead, faithful to their work. They know that they can take their skills anywhere in the field and be welcomed with open arms. Knowledge, skill, and work are now portable. It is valuable then for the clinical leader to be aware of the cultural and personal demands regarding work that exist within the prevailing culture. Incorporating symbolic and cultural norms in the language and process of change helps both format and discipline the change in a context the workers both understand and value. Every wise leader knows the politics of the environment and incorporates the political and relational realities well within the parameters of a change process so that the needs and roles of key stakeholders are incorporated into the efforts for meaningful and sustainable change.

The changes in nursing practice are just a fraction of the composite of the myriad transformations affecting nursing’s future. The innovative opportunities to address clinical practice for the future and to alter patients’ experiences of health care are unparalleled in human history. Nursing now must see itself differently in the same way that Florence Nightingale did at the beginning of the last century. New foundations must be laid, new practice parameters established, a different framework for nursing work instituted, a more knowledge- and accountable consumer taught and served, and new technology applied. All this calls for strong and effective clinical leadership from practicing nurses who can model transformative engagement in their own work and relationships. Time is of the essence for the nursing profession if it is to be relevant in this new century. Will we see nurses leading clinical change in 2050? Time will tell.

REFERENCES