Oates, Aaron R.

From: Therese Snively [tanively@mccn.edu]
Sent: Friday, November 18, 2011 10:06 AM
To: Library
Subject: MCHSL Web Form Submission: Article Request

Personal Information

Name: Therese Snively
Department: College of Nursing
Location: CLE 0119
Phone: 5-3362
Email: tanively@mccn.edu
Status: Faculty

Article Request

Rush Patient Care? No

Delivery Method: Email attachment

I am requesting more than one article and would like to be notified: as each article is received

Journal Title: Advances in nursing science

Article Title: Connective leadership for the 21st century: a historical perspective and future directions.

Article Author(s): Klakovich MD,

Year: 1994-06-01
Volume: 16
Issue: 4
Pages: 42
PMID (PubMed ID #):

Comments:

Submitted by 98.102.148.101

11/18/2011
NOTICE: WARNING CONCERNING COPYRIGHT RESTRICTIONS

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproductions of copyrighted material.

Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specific conditions is that the photocopy or reproduction is not to be "used for any purpose other than private study, scholarship or research." If a user makes a request for, or later uses, a photocopy or reproduction for purposes in excess of "fair use," that user may be liable for copyright infringement.

This Institution reserves the right to refuse to accept a copying order if, in its judgment, fulfillment of the order would involve violation of copyright law. 37 C.F.R. §201.14

PLEASE NOTIFY US WITHIN 48 HOURS IF YOU NEED US TO RECOPY/RESEND
Connective leadership for the 21st century: A historical perspective and future directions

Health care reform, layoffs, and hospital closures have created substantial stress for both nursing leadership and nursing staff. Literature suggests that nursing staff and leaders have not felt closely aligned and mutually supportive. An environment that provides a setting for renewal of caregivers and administrators is necessary to maintain nursing practice. A new leadership paradigm, connective leadership, is proposed to address problems of the past. Connective leaders, by empowering staff at all levels, facilitate the collaboration and ambiguity needed in the unprecedented health care environment of the future. Key words: administrators, connective leadership, empowerment. https://doi.org/10.1097/01.NURSE.0000042114.54472.3D

Marilyn D. Klassovich, RN, MSN
Adjunct Faculty
Nursing
Azusa Pacific University
Azusa, California
University of Phoenix, Southern California
Program
Everest Valley, California
Doctoral Candidate
University of San Diego
San Diego, California

The turmoil inherent in the massive overhaul of the US health care system creates substantial stress for nursing leadership and nursing staff alike. A study on role stress in hospital executives and nurse executives revealed that nurse executives had higher stress levels than hospital executives. The findings were attributed to the need for nurse executives to make management decisions in an extraordinarily complex and stressful environment. They are hence subject to role overload from working with multiple groups who each operate differently. More and more nurses are choosing to leave these positions or do not pursue them in the first place.

For some time, staff nurses have been pressured to do more with less—that is, to maintain high productivity without sacrificing quality. More recently, downsizing, layoffs, hospital closures, and mergers have created further uncertainty and conflict for the nursing staff.

Adm Nurs 30 1994;16(4):42-54
The perception of abandonment of frontline nurses by their nursing leaders further exacerbates the stressful conditions for nursing practice. Manschot indicated that the perceived abandonment resulted from the increased tendency to move the director of nursing services to the position of vice president for nursing or patient care services, with increased involvement of that individual in the complexity of overall hospital management. Consequently, the nurse executive became less visible to the staff nurse and appeared to have "joined the administrative elite." The concept of elitism also emerged in Simms’s description of the professional practice of nursing administration. Simms related that a 1983 Institute of Medicine study described a leadership crisis in nursing with a critical shortage of nursing administrators at all levels. From Simms’s perspective, "It is a crisis of our own making, for despite our sound beginnings, we have separated the components of administration from clinical practice and have forgotten essential links with education." She went on to say that we have prepared elites in administration who do not understand the importance of visionary leadership and staff involvement.

Where will nursing leaders for the 21st century come from if these trends continue? How can nurses continue to care for their patients in a stressful environment that devalues clinical practice and abandons or alienates staff nurses?

This article responds to these questions by tracing the historical evolution of administrative nursing practice, establishing the need for a new leadership paradigm for nursing, and proposing an alternative leadership model for the 21st century. "In re-turning to the past and following through to the present, nursing can apply guidance of the future of the profession." History can help the nursing profession deal with persistent issues and conflicts by shedding light on the profession's origins and by indicating trends.

AN HISTORY OF ADMINISTRATIVE NURSING

Florence Nightingale's school of nursing

Nightingale’s school of nursing

Florence Nightingale is considered the first "nurse executive." She integrated the functions of modern nursing care provision and management, interdisciplinary education, and scientific research. Modern nursing and hospital administration emerged from her work. Her 50-bed wards were models of the efficient use of personnel, and she emphasized control over resources, accounting, quality assurance, and statistics.

When Nightingale founded her school of nursing, she perceived two groups of nurses. The lady probationers, or "specials," were women from a higher class who were financially secure. Specials were separated from the others in living arrangements. They had less routine work duty and more study than the other probationers. The special nurses were usually better educated. Head nurses and experimenters were selected from the ranks of special nurses. These administrative positions offered an advanced scale of remuneration, an assured position, and considerable social and professional prestige.

What is this historical precedent for the elitism that distances staff nursing from nursing
administration. In her 1943 book on nursing education, Stewart warned that college-trained "degree" nurses would eventually be employed chiefly for managerial and teaching functions. The actual work of nursing would be done by a "subsidiary" group, with the potential for devaluing nursing practice and distancing the two groups from each other.

Early US hospitals

Although US schools of nursing did not establish two levels of nursing students, the better nursing schools wanted superintendents, teachers, and head nurses who were cultured women and educators as well as good practitioners. These nurses were accorded higher status based on their training at larger and more prestigious schools. The poorer students did not have the means, preparation, or access to attend those schools. Therefore, there were essentially two classes, even though it was not overt, as it had been with Nightingale's schools.12 As Reverby eloquently explained, "Nursing from its very beginnings created a female hierarchy in which sisterhood was difficult to achieve when different class-based assumptions about behavior and work collided."12

A historical instance of abandonment occurred during the time from the establishment of training schools in hospitals in the late 1800s until hospitals began to employ graduate nurses to provide nursing care in the late 1930s. During this time, nurses left the hospital setting on graduation and provided home care as private duty nurses on a case-by-case basis. Students provided hospital services. The nursing leadership of the time, predominantly superintendents of training schools, focused on the needs of the profession and their students and largely abandoned the graduates. Consequently, graduates grew apart from their training schools and developed strong resentments regarding their treatment. So early leaders championed the elite and never substantially identified with the day-to-day problems of nurses and nursing.13

1930s and 1940s: The bureaucracy

In the 1930s, hospitals recognized the advantages of employing graduate nurses. Technology was advancing, and graduate nurses constituted a cheap labor supply during the Depression when private-duty work was dwindling. However, nurses experienced difficulty returning to the bureaucratic hospital setting after functioning independently. The military and religious origins of health care institutions had resulted in rigid hierarchical structures and a dogmatic leadership style. Problems arose when the rules and regulations of the bureaucracy took priority over professional values.14

Nursing superintendents at this time were responsible for the organization and administration of the nursing service as a whole and of the school of nursing. They maintained standards, policies, and the budget. They were responsible for the employment and discharge of personnel, living condi-
Connective Leadership

The head nurse became the hospital equivalent of a factory line supervisor. Head nurses supervised all of the nursing care provided on their wards. They were also responsible for clinical teaching and supervision of the nursing students assigned to their areas. As Revery indicated, "turning out such human machines was generally the responsibility of each ward's head nurse." The importance of this role to the nursing department and to the hospital was recognized even then. Wayland and colleagues described "head nurses upon whom rests the greatest extent of the effectiveness and stability of the nursing service of the hospital and the direction of the students' learning experiences as the bedside of the patient." These authors emphasized the need to remain close to practice: "The head nurse is not cut off, as many nursing executives are, from the actual practice of nursing. Thus, problems had begun to surface due to a lack of visibility and close

nurse to practice roles on the part of the nurse executive.

According to Marx, in the 1930s and 1940s nursing administrators had similar social and cultural origins to those of their staff nurses. He alleged that staff nurses identified with their leaders and felt a sense of collective belonging when nurse executives "spoke only for nursing." His view is not confirmed by the above review, which suggests that this was not the case even in these early decades.

1940s and 1950s: Team nursing

With the onset of World War II, many graduate nurses were needed for the war effort. New categories of workers including nursing assistants, licensed practical nurses, aides, and technicians were introduced to provide nursing care. Hospitals were growing rapidly in size and complexity. Additional demands were placed on the head nurse to provide the supervision needed by these auxiliary nursing personnel with varying amounts and types of preparation. Team nursing was introduced in 1949 as a mechanism for other nurses to share the supervision responsibilities. With team nursing, the patients on a unit were divided among two or three groups of nursing staff. The most senior or most competent registered nurse would be designated as team leader. They would give treatments, distribute medicine, and supervise the nursing care provided by support staff.

The team nursing model seemed to further escalate nursing administration from the increasingly dissatisfied caregiving staff as the managers themselves provided less and less care. A study documented that staff nurses rated head nurses as better leaders if
the head nurses preferred nursing care activities over personnel and coordinating functions. This head nurse represented the traditional image of the nurse. The findings suggested that nursing personnel expected their head nurse to role model behavior for them.11

However, the head nurses’ superiors ranked them highly based on coordinating functions.12 At this time, head nurses were spending 30% of their time on clerical functions. In addition, they were expected to coordinate activities of patients, physicians, nursing staff, and other departments. To meet the demands of the job in accordance with expectations, the head nurses had to satisfy their superiors instead of the staff. In the 1950s and 1960s, schools began providing their own clinical instructors. This alleviated the head nurse’s workload in coordinating the clinical experience of the nursing students. However, the high turnover of different types of nursing personnel required the head nurse to focus on orientation, teaching, and the supervision of new staff members. Nursing care was becoming more complex and required continued updating of skills and knowledge.

1960s: Primary nursing

In 1966, primary nursing was established as a nursing care model. Primary nursing delegates decision making to bedside nurses. Prior to primary nursing, head nurses were still heavily involved in decision making, care planning, and teaching, and making rounds and contacts with physicians.13 With primary nursing, the head nurse became more of a resource, and the primary nurses assumed many of the other functions. The director of nursing’s role was to provide structure and support for professional nursing practice.

Primary nursing was an initial attempt to align nursing practice with professional nursing values. However, the centralized and hierarchical decision-making structures conflicted philosophically and operationally with the primary nursing model. Rigid hierarchical structures reduced the opportunity for creative nursing practice. The existing structures also were not geared to respond to the rapid change in health care. Nursing services were plagued by inflexibility, poor communication, and dissatisfaction.14

1970s: Decentralization

Decentralization became the means to move away from vertical organization with authority and decision making vested at the top. Decentralization was also a response to financial pressures that required the reduction of overhead. When this occurred, middle management layers were reduced or eliminated, and the scope of the nurse manager (formerly head nurse) role expanded. Nurse managers were now expected to assume responsibility for fiscal management, hiring and firing personnel, and accountability for professional practice.

With the expanded responsibilities of the nurse managers, directors of nursing became more of a resource to the nurse managers. They were to help them identify and meet learning needs, to reinforce responsibility for decisions, and to provide backup as needed. The philosophy was that patient care was the main priority and that all other activities revolved around this primary consideration.20 Nursing leaders of decentralized units had greater opportunities to establish closer working relationships and to

...
promote staff involvement and participation.  

1980s: Shared governance

In the early 1980s, nurse executive titles began to change from director of nursing to vice president. The corporate title of vice president conveyed a move to the executive level of the organizational hierarchy. The vice president was now considered a member of the executive management team and was responsible for participating in the overall decision making for the hospital. Two studies of nurse executive responsibilities conducted a decade apart revealed the marked expansion of responsibilities from the 1970s to the 1980s. In 1971, nurse executives agreed that their sphere of responsibility should be limited to nursing matters. They opposed the expansion of their roles to other administrative functions. In the 1984 study, however, most nurse executive roles had expanded to include non-nursing departments. The nurse executive typically had more employees and a bigger budget than any other administrator. These nurse executives believed that since nursing holds coordinating responsibility for care, the nurse executive must manage other patient care departments. They also recognized responsibility for contributing to the health needs of the community. Multitask agencies and services had added to the scope and complexity of the position.

With the expanded scope at the nurse executive level, Poulin also noted more evidence of decentralization and participative management in her second study. In the early 1980s, forms of shared or self-governance, committees, and task forces had been

In the early 1980s, nurse executive titles began to change from director of nursing to vice president, conveying a move to the executive level of the organizational hierarchy.
strainst and opportunities in the health care environment.

The nurse manager role remained important in the shared governance model as the communication link for the staff nurses. In 1989, the American Journal of Nursing conducted a survey asking staff nurses to describe "great head nurses." The results showed that in times of high stress with inadequate staffing, the first line manager was most important than ever. The staff nurses emphasized the importance of shared power and decision making, as well as communication and people skills.

Erevon-Bates' ethnography of nurse managers documented similar findings: "They just want me to be visible and around the unit, kind of to set the tone in some ways." Erevon-Bates saw the nurse manager role at the most difficult yet most critical position in the nursing organization—"the people who operationalize it and... make it happen."[26]

Porter-O'Grady[27] defined shared governance as a means to ensure the contribution of different roles to the success of the organization. He believed it would be the vehicle for "assuring the value and viability of nursing well into the 21st century." Modern while the philosophy of shared governance seemed viable as a mechanism for meaningful involvement of nurses, interviews with staff nurses revealed that many perceived shared governance as "lip service" or "delegate what the manager doesn't like to do" (M.D. Klakovich, unpublished manuscript, 1993). "One reason for this gap between reality and participatory ideals is that nurses at all levels of the organization are not clear about the mechanisms or pathways by which participation achieves its highly touted effects."[28]

1990s: Patient-centered care

Another problem with shared governance is that if the support departments remain centralized, there is little freedom and authority for professionals to problem solve on patient care units. Health care organizations are recognizing the benefits of worker involvement through new approaches such as continuous quality improvement and patient-centered care, or "transformed" organizations.

Patient-centered care is a philosophy that recognizes the interdependence of every department in achieving a quality product. Since patient care is a multifacted, multidisciplinary activity, decision making must be delegated to those involved in patient care processes. In true patient-centered care, the lines between management and direct caregivers are blurred.

Patient-centered care requires visible management. Intense communication is required to foster the involvement of staff nurses. The manager must be ever present to encourage nurses to be comfortable with change, innovation, and risk taking. Staff nurses must feel appreciated and valued as integral members of the hospital's health team.

The nurse executive, as the only member of senior management with both a clinical and financial perspective, plays a pivotal role in the success of patient-centered care.

Elitest originated with the two-class system in Nightingale's time and persisted through the various evolutions of nursing care models and organizational structures.
Wolf saw the primary role of the nurse executive as creating an environment where all departments can excel. Nursing staff must be empowered to operationalize their professional values. She viewed visible leadership as the key, which entails listening instead of talking and informal instead of formal communication.

Implications of historical review

While both Mauk and Simmerman alleged that elitism in nursing administration is a fairly recent phenomenon, a historical review of nursing administration suggests otherwise. The perception of abdication may be heightened now due to the turmoil in health care. However, it originated with the two-class system in Nightingale's time and persisted through the various evolutions of nursing care models and organizational structures.

The changes that have occurred in the last several decades (decentralization, shared governance, patient-centered care) seem to have the most promise for facilitating caring, professional nursing practice. However, to maximize their success, they must be implemented and sustained with appropriate leadership strategies so that the nursing staff will truly embrace these changes.

The American Hospital Association recently issued statements on the role and functions of the nurse manager and reaffirmed the role and functions of the nurse executive. The nurse manager is considered the vital link between the larger vision of the health care institution and the unit-based delivery of effective, high-quality care. Nurse managers are responsible for management of clinical practice, human resources, and fiscal resource, development of personnel; compliance with regulations; and strategic planning for their departments.

The nurse executive is the registered nurse on the hospital executive management team who is responsible for the management of the nursing organization and for the clinical practice of nursing throughout the institution. He or she is also charged with productive working relationships with the medical staff and support departments. In addition, the nurse executive must assess the environment, forecast trends, transmit values, communicate ideas, develop and implement policies, and initiate programs and systems.

Simmerman delineated additional role expectations for current and future nurse executives. They must enlarge their role in health policy-making by increasing their legislative expertise and activity. They must therefore be knowledgeable about economic, social, and political factors that affect health care and must work to change those factors for better health care for all. Finally, the nurse executive must be active in professional nursing and health care organizations.

With this variety of role expectations, one wonders how nurse executives and nurse managers can be effective without succumbing to the tremendous pressure. The answer lies with a more expansive and inclusive leadership strategy than has been historically experienced in nursing.

NEED FOR A NEW LEADERSHIP PARADIGM

The changes occurring in health care and in the world require a new kind of leadership: flexible networks to replace hierarchies, empowered workers who make their own decisions, and the acceptance of loving and caring as legitimate workplace motiva-


To deal with the stress inherent in the current system, both nursing leaders and caregivers must have a means for renewal in order to care for patients and for each other. Neher argued that nursing administrators, by virtue of their leadership roles, influence the enactment of caring values throughout the organization. They have the potential to develop mechanisms for caring practice and ongoing renewal of nursing professionals. Nursing leaders employ caring to "create an environment that nurtures creativity and intellect, fosters caring, and promotes fulfillment of success potential." They, as the leaders of the most critical departments to patient-centered care, must create a supportive, adaptive environment to maximize the contributions of the professional, knowledge-based worker. Previous emphasis on hierarchical leaders hastened people to devalue the interactive aspects of leader-follower relations. Nicoll suggested that society needs an interactive paradigm in which wisdom and meaning come from the interplay between leaders and followers.

Allen described an emerging paradigm of organizations, power, and leadership based on her field study of diverse voices of leadership. Leaders in the emergent power paradigm use strategies such as negotiating credibility (which includes trust, rapport, and respect), forming inclusive visions, and empowering diverse participants. Power is defined as an empowerment process that creates a sense of independence. Leadership is creating a shared vision and empowering people to achieve success.

Barker described the emerging paradigm as a new view of the world and of humaneness. This view is characterized by an emphasis on human relations and recognizing uncertainty in the world. To achieve success and excellence, she believes nursing needs moral leaders. They must have a vision for the future, based on caring and be able to match the health care needs of society with the needs of nurses for contributing to society.

A rapidly changing environment places changing demands on both leaders and followers: the double bind of maintaining quality with reduced resources, the expectations of shared power and responsibility, increased interdependence requiring collaboration and more open communication, and the need for renewal and continuous new competency development.

To preserve the caring practice of the nursing profession in today's health care environment, a new leadership theory is needed. This theory must allow nursing leaders to function effectively within the organization's culture, while empowering nursing staff through the provision of a caring professional practice environment. Furthermore, the theory must be congruent with a new leadership paradigm that can guide the nursing profession into the 21st century.

NURSING LEADERSHIP FOR THE 21st CENTURY: CONNECTIVE LEADERSHIP

Health care is moving "from its present fragmentation toward a seamless continuum of services." With the move to patient-centered care, patient care services in health
Connective leaders use a broad range of behavioral strategies to reach out beyond their own constituencies and take a systemwide perspective using mutual goals to create group cohesion.

Connective leadership is characterized by a new leadership theory that must allow nursing to function effectively within the hospital culture while empowering through the provision of a patient-centered environment. This theory must be congruent with the movement toward continuous improvement. Patient care services in health care organizations are increasingly interconnected. Care is being provided by cross-functional teams, and departmental boundaries have been blurred or eliminated. The culture, structure, and systems of tomorrow's health care organizations are in concert with global interdependence require a new, integrative model of leadership.

Leaders must often exceed the bounds of their given authority to bridge the gaps and divisions in organizations. Byrd emphasized the need for a leader to cope with the requirements of multiple constituencies. Health care organizations, in particular, exist within diverse communities (ethnic, religious, fraternal, geographic) that are all relevant to their performance and effectiveness. Additionally, health care organizations include many different occupations, many professions, lay governance, and volunteers.

Many chief nurses (CNs) are now assuming responsibility for non-nursing clinical services as well as hotel and support services. They must coordinate and facilitate multidimensional patient care services. The CN must facilitate a change in beliefs and values about other services to move health care organizations from “merely a grouping of local units competing” to a coordinated and integrated high-performing patient care organization.

This complex and interdependent environment, connective leadership has great merit for nurse administrators. Connective leadership is an integrative leadership model developed by Jean Lipman-Blumen based on extensive research with her Achieving Styles Model: "Connective leadership, which connects individuals creatively to their tasks and visions, to one another, to the immediate group and the larger network, empowering others and instilling confidence, represents a critical set of strategies for success, not only in the workplace, but in our interdependent world community."
stituencies: the medical staff, the board, hospital administrators, nursing staff, other departments, and the public.

Murphy and DeBuck's 13 in-depth interviews with 15 nurse administrators considered to be nursing care delivery change agents also revealed qualities of connective leadership. These leaders had mastered interdependence by creating strategic alliances, discouraging competition, and encouraging cooperation among all stakeholders in the change process.

In health care and in nursing, there is a need for leadership at every level. The historical review in this article indicated that nurses value the opportunity to provide leadership in clinical decision making and professional issues. Connective leaders bring many others into the leadership process and foster their ability to work synergistically. Connective leaders excel at recognizing and nurturing strengths in others and that include a broad range of individuals in the leadership process. Through appropriate mentoring and designation, CNEs can remain strategic players in both the organization and the external environment. This increases leadership strength at every level and reverses the issues of hierarchical control seen in earlier decades. Connective leadership permits leaders to share the burdens and the glory of accomplishment" (J. Lippman-Blumen, unpublished manuscript, 1993, p3-10).

While many leadership scholars who support the shift to a new leadership paradigm suggest that transformational leadership is what is now needed, this author believes that the emphasis on competition and conflict in terms of transformational leadership theory is no longer appropriate in today's health care environment. The two studies of effective CNEs lend support to this view. To effectively address health care reform while preserving nursing practice, connective leadership should be considered as a viable leadership model for nursing in the 21st century.

Connective leadership has great potential for empowering nursing staff and influencing positive outcomes for patients, nurses, and the organization. With this leadership strategy there is potential to provide a caring, professional practice environment with empowered nursing staff, promote collaboration among health care disciplines, and increase the contributions nursing makes to health care policy and delivery system changes.

... How do we rid our profession of the elitism that has systematically devalued nursing practitioners and begin to value what everyone contributes? If nursing is to achieve its purpose in society, nursing practitioners and nursing administrators must be aligned and working toward the accomplishment of mutual goals. Jennings and Meleis 11 argued for the use of theory to guide administrative nursing practice and to align clinical and administrative practice within a common framework. Connective leadership provides a model that will allow nursing to achieve this critical alignment. Nursing must also work collegially with other health care providers to accomplish these goals. The implementation of patient-centered care through connective leadership strategies can align nursing administrators with nursing practitioners, and it can also align nursing with other health care providers. Connective leadership may be the critical variable that enables nursing leaders to
model the organizational cultures of health care organizations and the external environment while maintaining the caring values of nursing.

REFERENCES


