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Nursing leadership 'when the chips are down':

Fighting a two-front war (from Crimea to Corona)

9th EfCCNa Congress 2022
Jaarbeurs, Utrecht, The Netherlands
Friday September 2nd

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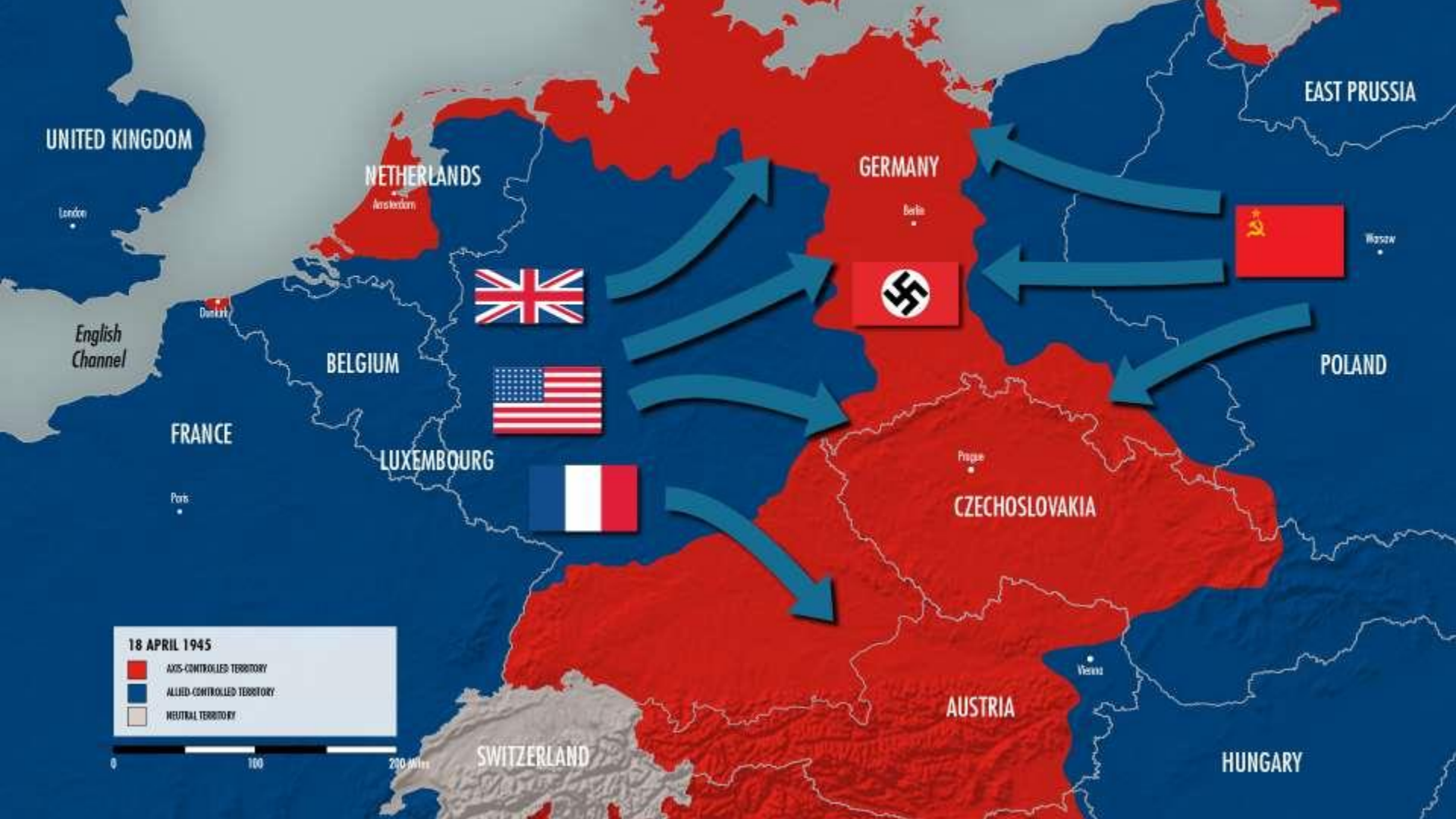
UNITED KINGDOM
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Amsterdam
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Berlin
EAST PRUSSIA
Warsaw
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Dunkirk
BELGIUM
FRANCE
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CZECHOSLOVAKIA
Vienna
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HUNGARY
18 APRIL 1945
AXIS-CONTROLLED TERRITORY
ALLIED-CONTROLLED TERRITORY
NEUTRAL TERRITORY
0
100
200 MILES

Learning histories

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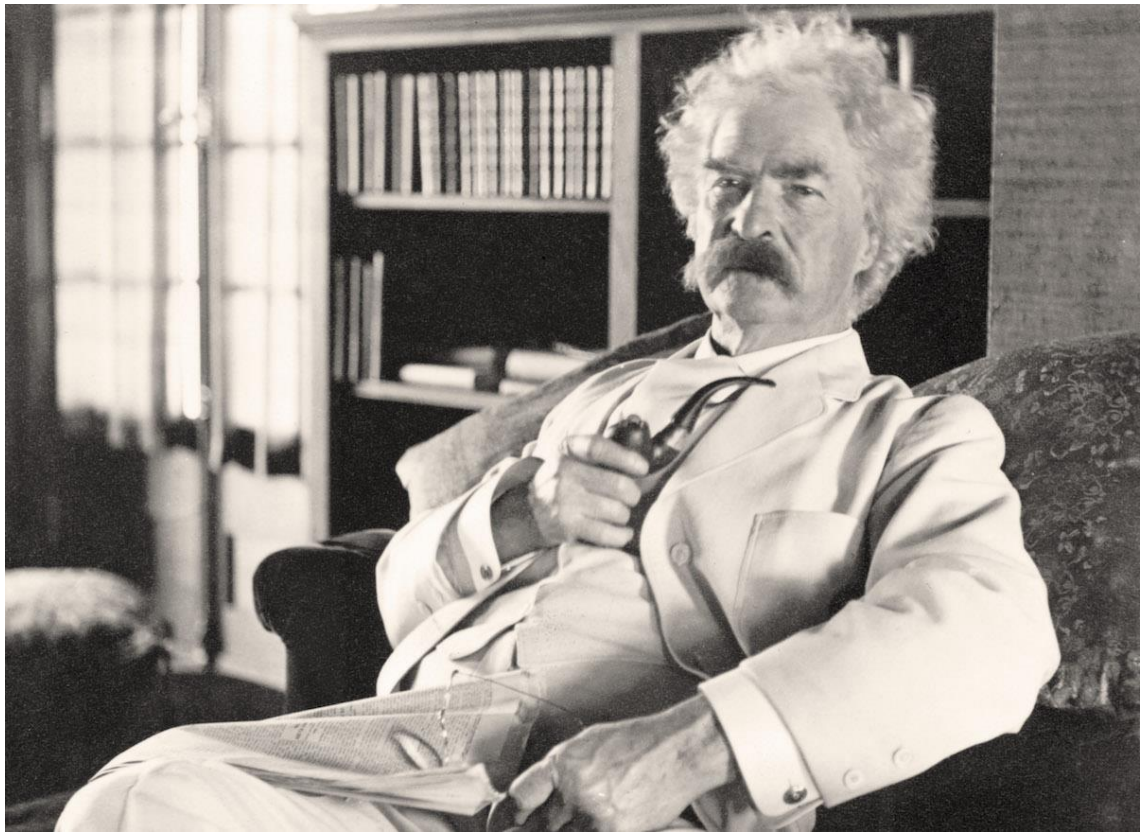
Learning histories is een actie-georiënteerde onderzoeksmethodiek die wij gebruiken bij de RN2Blend-studie naar gedifferentieerde inzet van verpleegkundigen.[1]

De *learning history*-methode is in 1996 geïntroduceerd door Art Kleiner en George Roth van de Society for Organizational Learning van het Massachusetts Institute of Technology (MIT). De methode richt zich op het onderzoeken van *remarkable findings* binnen een organisatie. Deze gaan over successen of fouten uit het (recente) verleden. Meestal worden de geleerde lessen hierover nauwelijks opgeslagen.[2,3] Het met elkaar optekenen van *remarkable findings* organiseert het collectief geheugen binnen de organisatie. Zo wordt leren mogelijk. Voor mensen binnen de organisatie zijn *remarkable findings* vaak vanzelfsprekend. Ze herkennen ze niet als opmerkelijk. Buitenstaanders zien dat vaak beter, vandaar dat samenwerking met externe onderzoekers cruciaal is.[2]
Werken aan een learning history leidt tot een tekst. Dit gebeurt door middel van interviews, dialogische reflecties en analyse. De klassieke vorm van Kleiner en Roth heeft een format van twee kolommen.[3] In één kolom zijn de deelnemers uit alle lagen van de organisatie aan het woord. Hierin staan hun verhalen. Dat wat zij hebben geleerd, is opgeschreven in hun eigen taal. Dit zal geen eenduidig verhaal zijn, meerstemmigheid laat juist ruimte voor verschillende visies en ideeën. Dat is belangrijk om daadwerkelijk te kunnen leren. In de andere kolom staan waarnemingen en reflecties van de externe onderzoekers.[2,4]
Vervolgens genereren de onderzoekers, in samenspraak met alle deelnemers, een eindproduct in de vorm van een 'verhaal', de learning history, gebaseerd op beide kolommen. Die samenspraak is essentieel volgens Roth en Kleiner. Het is de kracht van de learning history dat iedere participant zijn of haar kant van het verhaal herkent in de tekst, zich gehoord voelt en ook begrijpt hoe anderen tot bepaalde inzichten zijn gekomen.[3]
Deze learning history wordt binnen de organisatie verspreid om verdere gesprekken mogelijk te maken. De learning history kan verschillende vormen aannemen, bijvoorbeeld een geschreven tekst die 'het verhaal' of de *(hi)story* vertelt. Het kan ook een theatervoorstelling, PowerPointpresentatie of digitaal beeldmateriaal zijn.[2,5] Het is belangrijk de vorm zorgvuldig te kiezen met



History does not repeat itself, but if often rhymes – Mark Twain

Crimean War (1853-1856): *when nurses tackled a crisis*

Nursing leadership as blended care according to Florence Nightingale. From her book *To her nurses*. Letter from May 23rd 1873.

1. Have a real and personal interest for each one of your patients.
2. Have a strong practical (intellectual if you will) interest in the case. This is what makes the true nurse. Otherwise the patients might as well be pieces of furniture, and we the housemaids.
3. The pleasures of administration, which though a fine word, means only learning to manage a ward well.

The Great War (WO I)

Introduction

In February 1915 the Dutch nurses' union Nosokomos (founded in 1900) responded in a Dutch newspaper to the conservative attitude towards (war) nurses, as expressed by the board of the Dutch Red Cross (DRC). Women were, the DRC had stated, nurses by nature. All a good nurse had to have, was a kind and gentle heart. But, Nosokomos argued, nursing isn't charity. It is not solely an act of a good-hearted woman, treating her patients, looking upon her patients, as a mother would treat and look upon her children. It is not a consequence of so-called female kindness. It is a duty coming out of the right of men to be taken care for after having done their bit in warfare. It is therefore a state task, to be performed by well-trained, professional nurses who deserved to be well-paid for their job![1]

FIRST WORLD WAR STUDIES
https://doi.org/10.1080/19475020.2021.1878046

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Dutch nurses and the Great War: on caregiving and gender

Leo van Bergen and Catharina Th. Bakker

Independent Scholar, Netherlands

ABSTRACT

In 1910 female nurses were allowed to work in Dutch military hospitals. However, it proved difficult to find them. The blame was partly directed at nurses themselves: they didn't have the right background and didn't fit into military, male discipline. The nurses themselves blamed the Dutch Red Cross who had failed in its mobilizing task. The typical Dutch situation – neutrality resulting in a lack of urgency to create a strong military nursing corpse – thus gave rise to discussions on femininity and professionalism in military nursing. The war also provoked criticism of militaristic use of female care and again neutrality was at the bottom of this. Dutch nurses working in warzones could write more easily about the horrors they witnessed, leading to questions about the role of wartime medicine. During the interwar period the peace movement made medical care one of its targets. This pacifist protest was shared by some female nurses. They too described women as 'mothers' and 'givers of life', just like (male) soldiers and officers who stood up for female war nurses, but with opposite intentions. Instead of being 'disciplined' and 'chaste', they sought the right preconditions to be able to do their job properly, thus leading to critique on – for example – the uncomfortable nurses' uniforms. Though the critique attracted some attention, it did not last, partly because of another war coming. In this war finally 'real' female war nurses went to work. Although disagreeing with the critique itself, as far as their uniform concerned, they were happy to benefit from the pacifist-feminist critique.

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Nursing; Netherlands; pacifism; militarism

Introduction

In February 1915 the Dutch nurses' union Nosokomos (founded in 1900) responded in a Dutch newspaper to the conservative attitude towards (war) nurses, as expressed by the board of the Dutch Red Cross (DRC). Women were, the DRC had stated, nurses by nature. All a good nurse had to have, was a kind and gentle heart. But, Nosokomos argued, nursing isn't charity. It is not solely an act of a good-hearted woman, treating her patients, looking upon her patients, as a mother would treat and look upon her children. It is not a consequence of so-called female kindness. It is a duty coming out of the right of men to be taken care for after having done their bit in warfare. It is therefore a state task, to be performed by well-trained, professional nurses who deserved to be well-paid for their job![1]

Spanish flu: *again nurses in the frontline*

Emergency hospital during influenza epidemic, Camp Funston, Kansas, probably early 1918. (OHA 250: New Contributed Photographs Collection, Otis Historical Archives, National Museum of Health and Medicine)

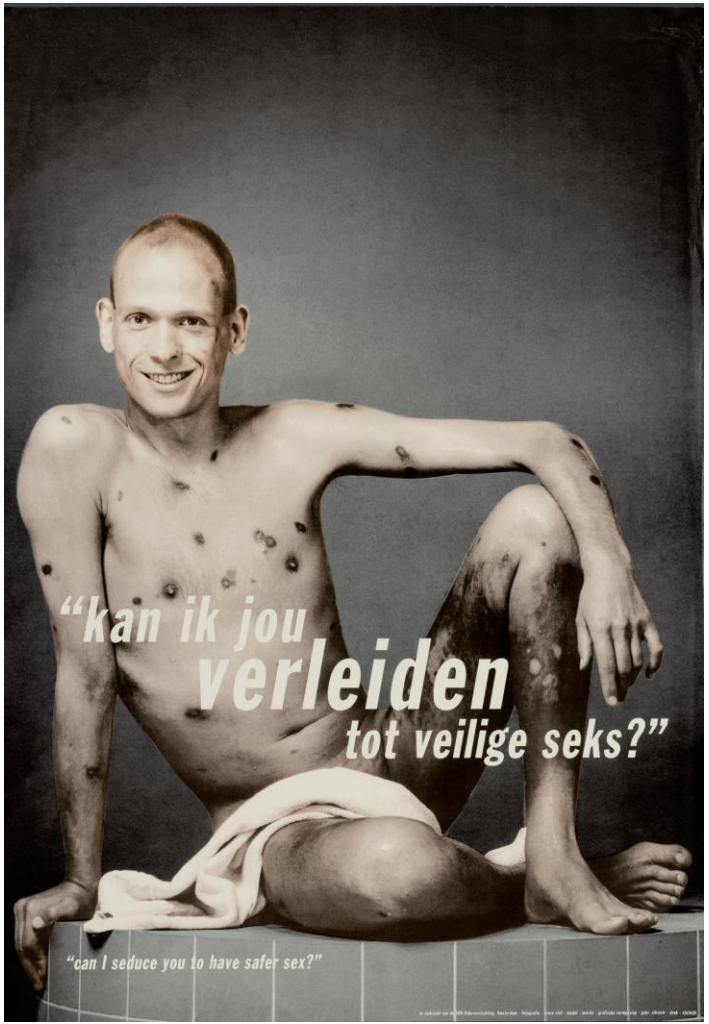
'If you would ask me the three things Philadelphia most needs to conquer the epidemic, I would tell you, 'Nurses, more nurses and yet more nurses.' [1]

1. Hanink, E. 'Nursing during the Spanish flu epidemic of 1918.' www.workingnurse.com (2018)

Another pandemic

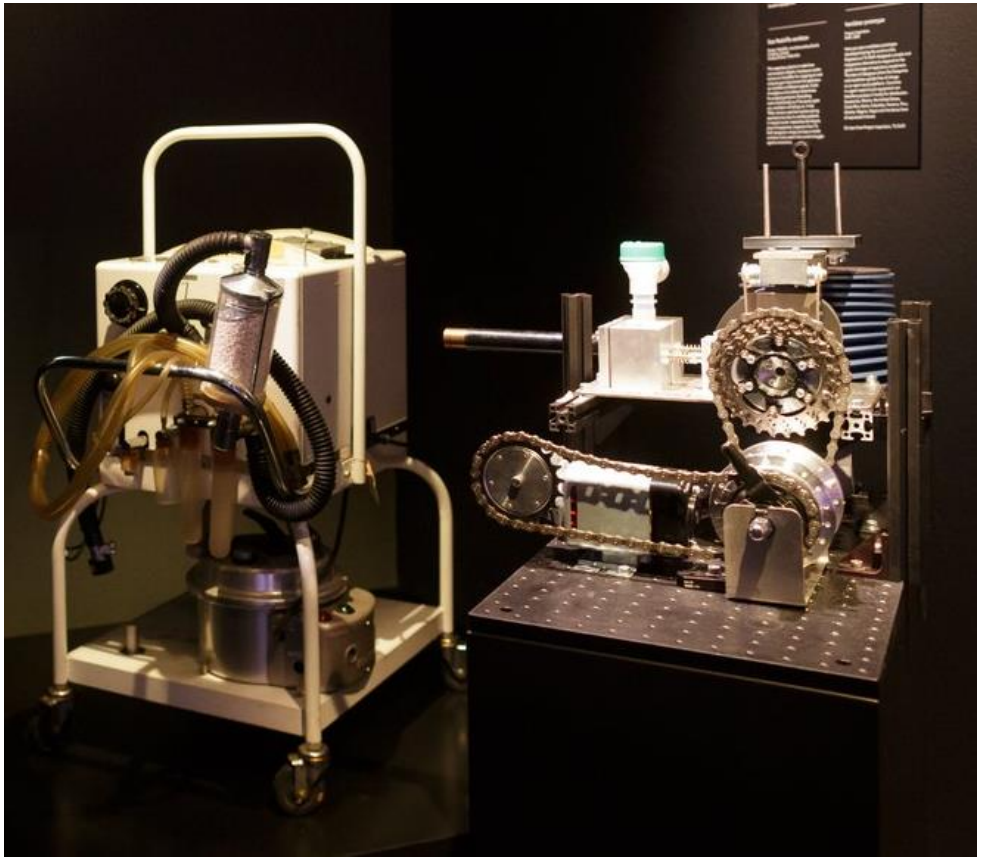
- *“Can I seduce you to have safer sex?”*
- Again no cure
- Mysterious disease
- Boosting professionalism
- Visit exhibition House of HIV in Amsterdam (40 ‘anniversary’)

- Nobel price goes to the vaccine…



Picture: Erwin Olaf

Finally COVID-19: CONTAGIOUS! / BESMET!:



Fontys

Histories of nursing: The power and the possibilities

Patricia D'Antonio, PhD, RN, FAAN
Cynthia Connolly, RN, PhD
Barbra Mann Wall, RN, PhD
Jean C Whelan, RN, PhD
Julie Fairman, RN, PhD, FAAN

This article challenges the dominant paradigm of understanding the history of nursing as only that of relative powerlessness. By moving away from the stance of educators deeply concerned about the inability of the profession to gain control over entrance requirements and into the realm of practice, we use examples from our own work to discuss alternate histories of power. We acknowledge historical circumstances of invisibility and gender biases. But we argue that when we look at the history of practice, we see as much evidence of strength, purpose, and successful political action. Finally, we call for an acknowledgement of the rich and complex nature of the many different histories we can tell in nursing. And we suggest that an admitted inability to advance in one area of the discipline has not meant an inability to move in others.

History matters. And it seems to matter now more than ever in our collective memory. Each day, public commentators report on how history and historical perspectives have informed the national debate about who we are, as a society, as citizens; what we want as a nation; and how we might move forward in addressing the most serious economic crisis of our generation. When studying the words of these commentators, it seems clear that there is not "one" history—that there is not one prescriptive formula that provides a simple solution or explanation for complicated problems. Rather, they present many histories—each starting from a particular stance, using different sources, and offering distinct perspectives. Still, when considered as a whole, these histories provide a much richer understanding of factors and forces that inform broad social policy and particular local practices. They bring real complexity to the forums in which the debate occurs. And they illuminate the complicated dynamics of power that are called into play when deeply held interests and issues need resolution.

History matters to nursing in the same way. And it matters more today now that issues of healthcare policy and practice, so central to the mission of the profession, have re-engaged the public agenda. We write out of concern that there seems to be only one familiar history to which nurses turn as they consider their place in this process. This history has often been written from the stance of educators deeply concerned about the inability of the profession to control the many different educational routes to nursing practice. Its sources have been a long list of 20th-century reports on the status and future of nursing education. Its perspective has given voice to the language of education and educational reform as a proxy for nursing's power. In the end, its story is

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Barbra Mann Wall, RN, PhD, is an Associate Professor of Nursing and

All these crises show:

We are powerful!
We can take the lead
We are innovative
We do not give up

But there are more fronts!

Critical on nursing leadership

Nursing Inquiry

Nursing Inquiry 2013; 20(1): 11–22

Feature

Transformational leadership in nursing: towards a more critical interpretation

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HUTCHINSON M and JACKSON D. *Nursing Inquiry* 2013; **20**: 11–22

Transformational leadership in nursing: towards a more critical interpretation

Effective nurse leadership is positioned as an essential factor in achieving optimal patient outcomes and workplace enhancement. Over the last two decades, writing and research on nursing leadership has been dominated by one conceptual theory, that of transformational leadership. This theoretical framework has provided insight into various leader characteristics, with research findings presented as persuasive evidence. While elsewhere there has been robust debate on the merits of the transformational model of leadership, in the nursing literature, there has been little critical review of the model and the commonly used assessment instruments. In this article, we critically review more than a decade of nursing scholarship on the transformational model of leadership and its empirical evidence. Applying a critical lens to the literature, the conceptual and methodological weaknesses of much nursing research on this topic, we question whether the uncritical adoption of the transformational model has resulted in a limited interpretation of nursing leadership. Given the limitations of the model, we advocate embracing new ways of thinking about nursing leadership.

Key words: leadership, nursing, transformational leadership.

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The essentials of nursing leadership: A systematic review of factors and educational interventions influencing nursing leadership

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ABSTRACT

Background: Nursing leadership plays a vital role in shaping outcomes for healthcare organizations, personnel and patients. With much of the leadership workforce set to retire in the near future, identifying factors that positively contribute to the development of leadership in nurses is of utmost importance.
Objectives: To identify determining factors of nursing leadership, and the effectiveness of interventions to enhance leadership in nurses.
Design: We conducted a systematic review, including a total of nine electronic databases.
Data Sources: Databases included: Medline, Academic Search Premier, Embase, PsychInfo, Sociological Abstracts, ABI, CINAHL, ERIC, and Cochrane.
Review Methods: Studies were included if they quantitatively examined factors contributing to nursing leadership or educational interventions implemented with the intention of developing leadership practices in nurses. Two research team members independently reviewed each article to determine inclusion. All included studies underwent quality assessment, data extraction and content analysis.
Results: 49,502 titles/abstracts were screened resulting in 100 included manuscripts reporting on 93 studies (n=44 correlational studies and n=49 intervention studies). One hundred and five factors examined in correlational studies were categorized into 5 groups – *experience and education*, individuals' *traits and characteristics*, *relationship with work*, *role* in the practice setting, and *organizational context*. Correlational studies revealed mixed results with some studies finding positive correlations and other non-significant relationships with leadership. Participation in leadership interventions had a positive impact on the development of a variety of leadership styles in 44 of 49 intervention studies, with relational leadership styles being the most common target of interventions.
Conclusions: The findings of this review make it clear that targeted educational interventions are an effective method of leadership development in nurses. However, due to equivocal results reported in many included studies and heterogeneity of leadership measurement tools, few conclusions can be drawn regarding which specific nurse characteristics and organizational factors most effectively contribute to the development of nursing leadership. Contextual and confounding factors that may mediate the relationships between nursing characteristics, development of leadership and enhancement of leadership development programs also require further examination. Targeted development of nursing leadership will help ensure that nurses of the future are well equipped to tackle the challenges of a burdened health-care system.

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What is already known about the topic?

- Relational leadership styles in healthcare organizations are critical for improving staff and client health outcomes.
- Previous research has identified educational activities as promising interventions for developing leadership practices.

What this paper adds

- Factors such as age, nursing experience and emotional intelligence may be positively correlated with leadership behavior and practice, however weak study designs and poorly

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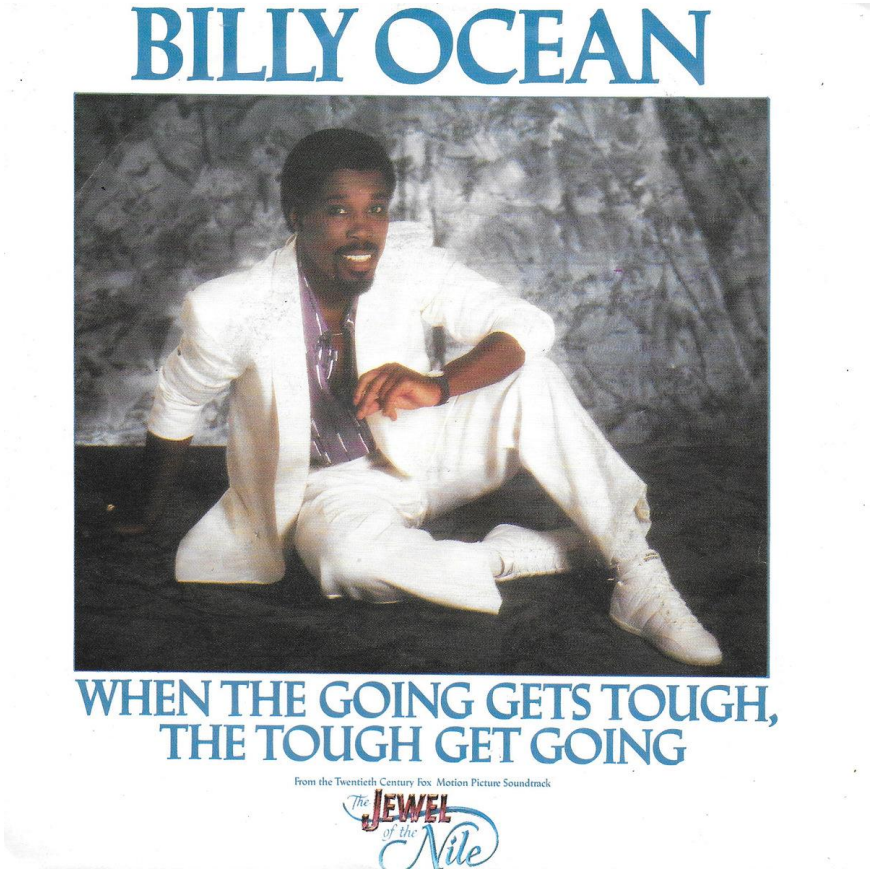
“When the chips are down” (Arendt)

When the going gets tough…(Ocean)*



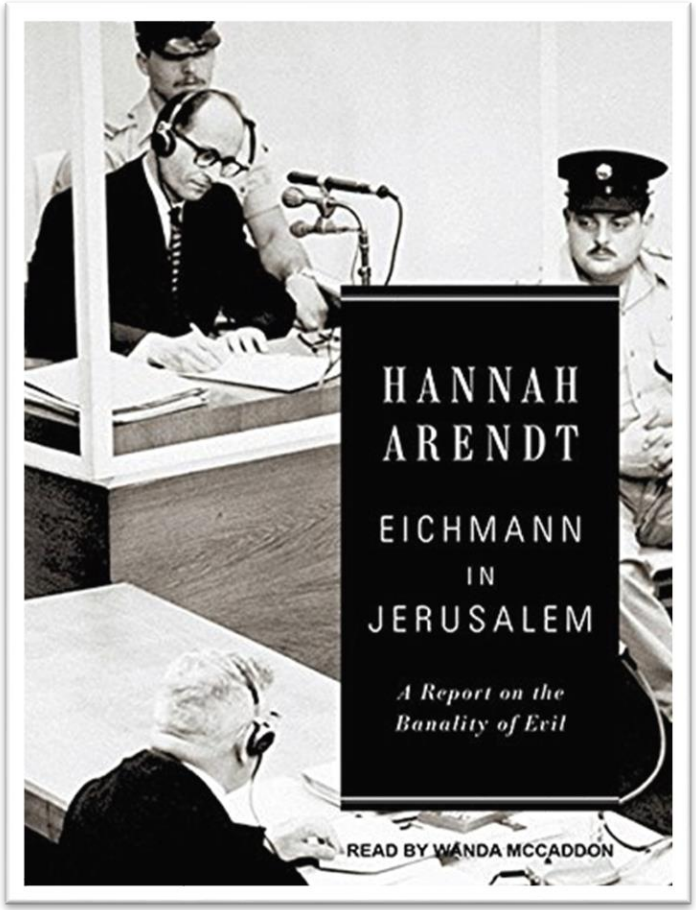
“When the chips are down” (Arendt)

Human Condtion (1958)
- Work
- Labor
- Action

- Judgment / opinion / politicize

- Action – in the public sphere
- Speak up – be critical

Eichmann in Jerusalem (1963)
- Uncritical toward ‘system’
- Banality of evil



	CRAFT	INDUSTRIAL	KNOWLEDGE
Organization	• Cottage Industry	• Stand-alone professional bureaucracy	• High-tech collaborative learning organization
Game type	• Autonomy	• Control	• Cooperation
Business model	• Personal relationships • Reputation	• Price • Scale • Service	• Community needs • Prevention • Health improvement
Leadership model	• Master-apprentice • Mentoring	• Managerial	• Visionary • Dialogue • Motivating
Quality and cost control	• Peer review	• Statistical process control • Utilization management • Outcome measures • Clinical pathways	• Continuous improvement • Shared responsibility
Values	• Caring • Professional trust • Expertise	• Service • Profitability	• Teamwork • Innovation
Hannah Arendt's Human Condition	• Work (homo faber / the Craftsman)	• Labor (animal laborans / the laborer)	• Action (political thinking and judgment)

Tabel 1: Transformatie, speltype en leiderschap. Maccoby (2013) / Keidel (2010) / Hannah Arendt (2013)

Fontys

Article

Public Opinion Leadership in Nursing Practice: A Rogerian Concept Analysis

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Abstract

In the Dutch nursing context, work remains in strengthening the voice of nurses serving as frontline health care providers and board members alike. Conceptual clarity of Public Opinion Leadership (POL) in nursing practice is needed to provide attributes, antecedents and consequences for nurses and nurse leaders so they can contribute in the public debate and policy making processes. Using Rodgers' method of evolutionary concept analysis and the key words "POL," "lobbying" and "public affairs," we searched PubMed (including MEDLINE), CINAHL, PsycINFO and Cochrane Library for articles written in English, published between January 1999 and May 2020, which resulted in a final selection of seven studies. In addition, transcripts of an expert panel discussion regarding POL were analyzed. Attributes of POL are credibility, accessibility, altruism, dynamic networking and sense of systemness. Antecedents are a clinical background, authentic authority, policy and political awareness and strategic skills. The main consequences of POL entail influencing those who are involved in policy making processes, a new generation of public opinion leaders, and the raising of bottom-up political leaders. POL is a relatively new concept for nursing, with increasing interest given the need to ensure quality of care by increasing the use of evidence in clinical practice. POL in nursing practice is defined as the action of influencing public debate regarding policy making processes by maintaining dynamic (social) networks, having a high sense of systemness, and being (clinically) credible, altruistic and accessible to peers and a wide variety of stakeholders.

Keywords

concept analysis, influence, leadership, policy making, public opinion leadership, quality of care

Introduction

Internationally and in the Netherlands, nurses and nurse leaders are called to show and strengthen their influence to advance the frontline of patient care and the healthcare public policy arena. Recently, Sundean et al. (2020) cites Adams et al. (2019, p. 398) to underscore the challenges of this call, "Nurses" contributions are often completed while leading quietly from the back. This, however, likely has limiting and possibly a detrimental effect on the health of our population." Although written for an American audience, this quote resonates in the Dutch nursing context where both frontline nurses and board members remain relatively voiceless on crucial healthcare issues on a local and national level. For example, less than 15% of Dutch hospitals have board members with a nursing background (NOS, 2019).

In Dutch clinical practice settings, a recent surge of shared or professional governance structures promotes the inclusion of nurses' knowledge, skills, and expertize in organizational decision making (Lalleman et al., 2020) and implementation of evidence-based practice (EBP) (van der Goot et al., 2018; van Schothorst–van Roekel et al., 2021). Other literature would describe such knowledge, skills, and expertize of nurses as *local* opinion leadership (LOL) (Flodgren et al., 2019). However, this type of opinion leadership only encapsulates clinical practice, while missing board services and health policy as crucial areas of governance. Therefore, we used LOL as our anchor and starting point for further development and exploration of *public* opinion leadership (POL) in nursing practice.

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REVIEW

Journal of Clinical Nursing WILEY

A scoping review of rebel nurse leadership: Descriptions, competences and stimulating/hindering factors

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Abstract

Aims: To (1) give an overview of rebel nurse leadership by summarising descriptions of positive deviance, tempered radicals and healthcare rebels; (2) examine the competences of nurse rebel leadership; and (3) describe factors that stimulate or hinder the development of rebel nurse leadership.

Background: Research shows nurses have lower intention to leave their jobs when they can control their work practices, show leadership and provide the best care. However, organisational rules and regulations do not always fit the provision of good care, which challenges nurses to show leadership and deviate from the rules and regulations to benefit the patient. Three concepts describe this practice: positive deviance, healthcare rebels and tempered radicals.

Design: Scoping review using the Joanna Briggs Institute methodology and PRISMA-ScR checklist.

Methods: Papers describing positive deviance, healthcare rebels and tempered radicals in nursing were identified by searching Scopus, CINAHL, PubMed and PsycINFO. After data extraction, these three concepts were analysed to study the content of descriptions and definitions, competences and stimulating and hindering factors.

Results: Of 2705 identified papers, 25 were included. The concept descriptions yielded three aspects: (1) positive deviance approach, (2) unconventional and non-confirmative behaviour and (3) relevance of networks and relationships. The competences were the ability to: (1) collaborate in/outside the organisation, (2) gain and share expert (evidence-based) knowledge, (3) critically reflect on working habits/problems in daily care and dare to challenge the status quo and (4) generate ideas to improve care. The factors that stimulate or hinder the development of rebel nurse leadership are as follows: (1) dialogue and reflection, (2) networking conditions and (3) the managers' role.

Conclusions: Based on our analysis, we summarise the descriptions given of rebel nurse leadership, the mentioned competences and provide an overview of the factors that stimulate or hinder rebel nurse leadership.

Nursing leadership (my) blindspot

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REVIEW ARTICLE

Journal of Clinical Nursing WILEY

Intersectionality and nursing leadership: An integrative review

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Abstract

Aims and objectives: This review aimed to synthesise international research about how intersectionality has been used to explore issues within the nursing profession. The objectives were to determine which intersecting variables have been explored, how intersectionality has been operationalised, and the implications for nursing leadership.

Background: Barriers to health system leadership created at the intersection of gender, race, ethnicity, professional cadre and other socially constructed categories exist in the health workforce. Consequently, an intersectionality paradigm has been recommended to explore power, privilege and oppression issues in the nursing profession.

Design: An integrative systematic review method was selected for its ability to include diverse methodologies. The review complies with the PRISMA guidelines for reporting systematic reviews.

Method: The search terms nurs* nurses nursing AND Intersectionality intersectional intersectionalism, intersect were used in December 2021 to search the Cumulative Index to Nursing and Allied Health Literature (CINAHL Plus) PsycINFO, PubMed, Ovid, ProQuest and the first ten pages of Google Scholar from 2011 to 2021. Directed content analysis was applied to the data.

Results: Access to education, absence of expectations as a career and patriarchal structures support male nurses into positions of leadership in healthcare systems. Intra-group differences highlight the paradox of homogenous categories for ethnicity and gender. Being a member of an ethnic minority group hinders career progression regardless of gender. The aftereffects of colonisation exist within the nursing space.

Conclusions: This review is the first to synthesise research using intersectionality to explore the impact of socially constructed identities on nursing leadership. There is a dearth of evidence specific to this topic, ignoring the diversity within this professional group. Future research should include intersectionality to discover how social categories empower or impede a nurse's career progression to leadership roles.

Relevance to clinical practice: An intersectionality paradigm can encourage nurses to attend to issues of power, privilege and oppression in the profession and their practice.

KEYWORDS
Intersectionality, Leadership, Nursing

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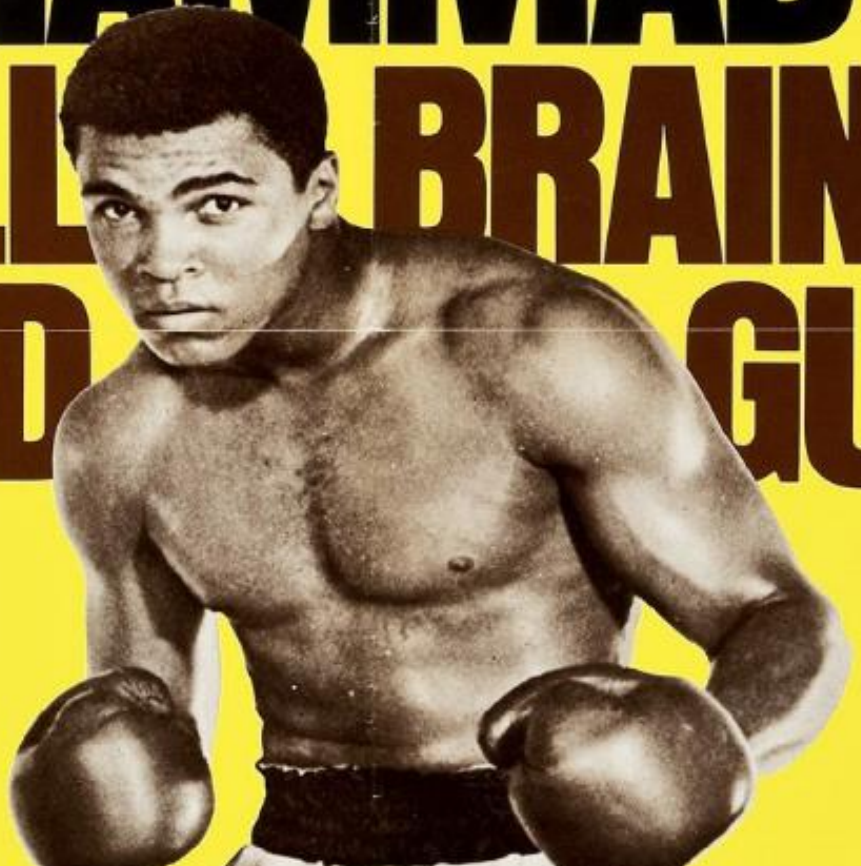
Fontys

MUHAMMAD ALI

SKILL BRAINS AND GUTS



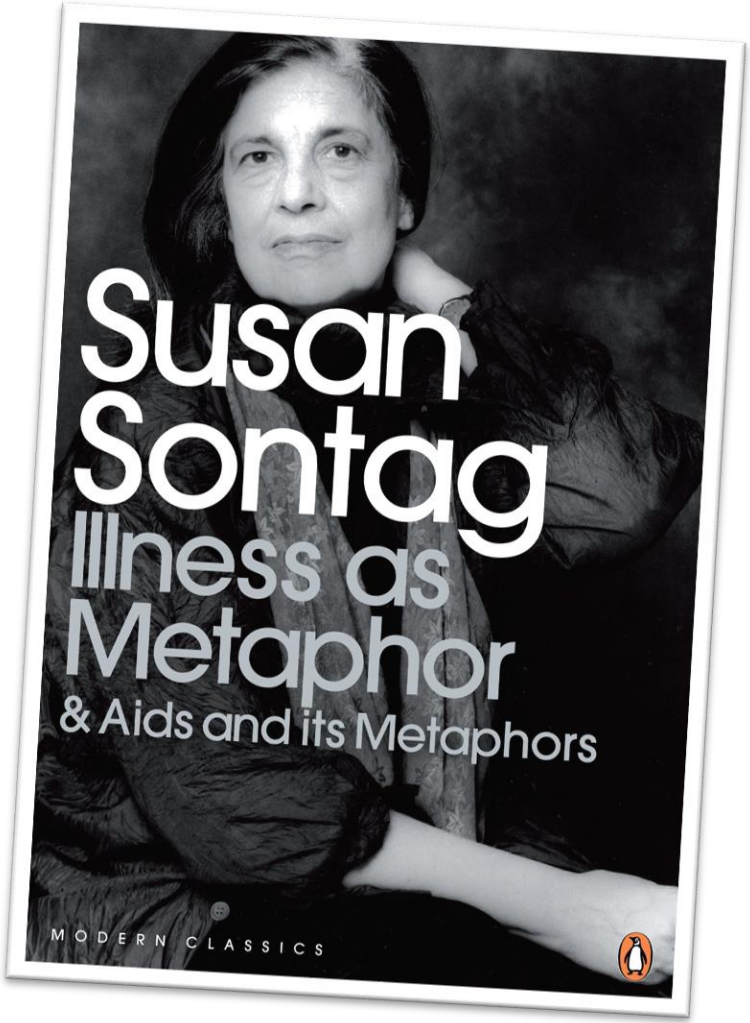
Intermezzo: The use of metaphors

Modern nursing is ‘born’ in a war

- COVID as a war & fighting the virus

- Disease-as-war language (TB, Cancer, AIDS)
- Discouraged, silenced, and shamed patients

- With a reason according to Baehr (2006)
- Expresses someting real, vital, not firvolous
- Articulates collective fear and homage



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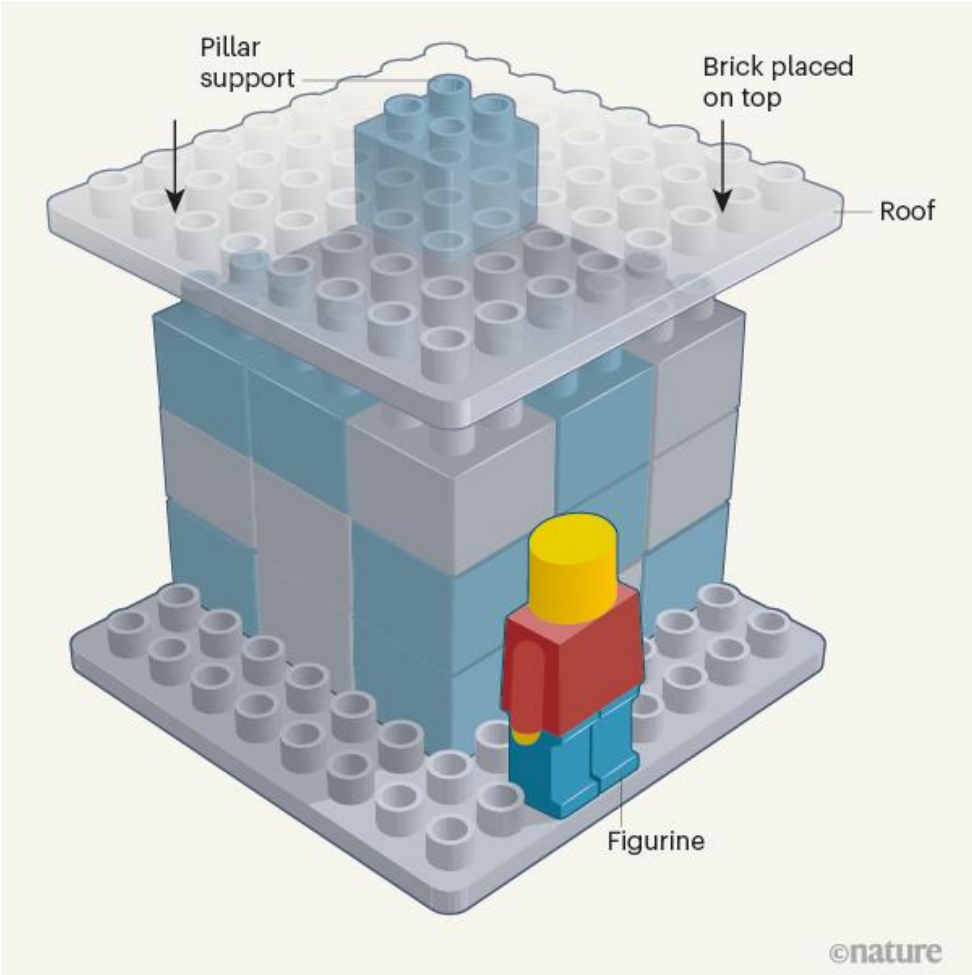
How to ‘fight’ a two front war as an opionleader?

Patient care

Policy & Politics

- Start the (public) debate
- Issue: staff shortage / quality
- We will get **less with less**
- We can not provide all care possible in the future
- Difficult (ethical) discussion
- Difficult because brains always want more (Adams et al 2021)
- Extra difficult for nurses because of Disposition to care (Lalleman et al 2018)
- Focus on *degrowth* in healthcare?



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Start exploring the 'other' frontline through shadowing

Peer-to-peer shadowing as a technique for the development of nurse middle managers clinical leadership

An explorative study

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Fontys

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