Nursing Leadership
Oxymoron or Powerful Force?

Constance M. Savage, PhD

Nursing leaders face many challenges on a daily basis. However, the fundamental challenge is addressing the impact of culture – societal, organizational, and professional – that keeps nursing executives tied to the tactical when their energies should be directed to more long-term, strategic outcomes.

Cultural impact, combined with education and professional experience that emphasize a hands-on approach, surreptitiously works to incapacitate nursing leadership, threatening to transform the term “nursing leadership” into an oxymoron.

To ameliorate this situation, nursing leaders must shift focus from tactical to strategic, concentrating on the future state and the larger picture. To accomplish this, nursing leaders must build bench strength so their direct reports can act as fully functioning agents for nursing leadership. Further, nursing leaders must adopt a systems approach to better leverage the dynamics of interdependencies that are intrinsic to effective and efficient health care delivery.

Ultimately, nursing leadership must effectively transition from the operational (doing) aspect of work to the strategic (reflective) element of work by combining action and thought, thus making nursing leadership a force to be reckoned with.

Words that Collide

You’ve heard them before: “jumbo shrimp,” “working vacation,” “virtual reality.” They are oxymorons and they highlight the fundamental contradiction in common phrases...
Searching for Answers to Critical Questions

Dear Colleagues,

When the AAACN Board of Directors left the association’s annual meeting in April, we were focused on finding answers to several critical questions:

• How do we articulate the value of AAACN to our customers, our corporate sponsors, our employers, and our professional community?
• How can we articulate a strategy to achieve and maintain financial stability within the next 3 years?

Add to those an additional question that arose at our June Board meeting:

• How do we establish meaningful connectivity between the national organization and our grassroots members?

What follows is an update on where we stand regarding the answers to those questions. Please keep in mind that as the Board seeks answers, we constantly keep in mind AAACN’s goals and strategic plan. We also strive to fulfill AAACN’s tagline, “Real Nurses, Real Issues, Real Solutions.”

Critical Question 1: How can we articulate AAACN’s value to our customers, corporate sponsors, employers, and professional community?

• Corporate sponsors – One of our most important tasks is to identify AAACN’s value to corporate sponsors. To that end, we are thinking about providing corporate sponsors with our demographic data. This would give the sponsors a better understanding of the far-flung reach of the ambulatory care nurse; and depth and breadth of our practice. We also want to enlighten sponsors about the wide variety of ambulatory care nursing health care sites and the influence nurses have on selecting and purchasing clinical equipment. Finally, it is important for them to have an accurate understanding of how their products and services may be used in ambulatory care settings.

• Our customers (AAACN members) – We know our value and we know what AAACN members want from their professional organization. Now we have to devise a plan to make the valued membership benefits a living part of AAACN. To that end, these are some of the ideas we are considering:

  • Providing more tools ambulatory care nurses can use immediately in their work environment.
  • Providing access to experts (consultants and speakers) by developing a consultant/speakers bureau.
  • Posting Web page updates of critical nursing issues nationwide as well as pending or approved legislation that addresses key issues.
  • Expanding opportunities for member involvement in the organization and for mentoring evolving AAACN leaders.
  • Offering special pricing incentives to large-volume purchasers of our Standards and other products.
  • Allowing exhibitors to attend sessions at the annual meeting.

• Holding focus groups at each annual meeting to find out what they would like to see in the exhibit hall and how we can make the hall a more enticing part of our annual conference.

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Bridging the Language Barrier

Imagine yourself needing health care in a country where you don’t speak or understand the language. You have to depend on an interpreter to explain your symptoms to a provider. Would you seek the help of a stranger? Call a family member who took a language class in high school many years ago? How would you cope?

Language dilemmas in health care settings occur daily throughout the United States. The problem is a serious one, compounded by the national nursing shortage and a severe lack of qualified interpreters and translators.

Health care organizations can meet this challenge by writing clear and concise policies and procedures that address the needs of individuals who have limited English proficiency. Organizations should be cognizant of current laws and regulations that address compliance with confidentiality standards.

The interpreter’s or translator’s proficiency is crucial in helping the patient make the correct decision. Therefore, health care facilities should review their methods for evaluating interpreters and translators and establish a process to validate their competency.

Those providing language services should have:
- A high level of comfort with medical terms
- The ability to explain medical terms in a way patients can understand.
- An understanding of the patient’s beliefs, behaviors, and needs.

The flowchart shown in Figure 1 demonstrates the major steps in solving a patient/provider language barrier, from identifying the patient’s need for an interpreter to establishing a rapport for effective communication.

Role Definition

It is important to clarify the difference between a translator and an interpreter. The roles are often considered interchangeable, however, a translator is someone who works with written words and an interpreter, spoken words.

Various organizations throughout the United States have defined the role of interpreters and translators. According to the National Council on Interpreting in Health Care (NCIHC) “An Interpreter is a person who renders a message spoken in one language into a second language, and who abides by a code of professional ethics” (NCIHC, 2001).

NCIHC also defines interpreting as “The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another language, taking the cultural and social context into account” (NCIHC, 2001).

According to NCIHC, translation is “The conversion of a written text into a corresponding written text in a different language” (NCIHC, 2001).

Cultural Competency

When using interpreters in the clinical setting, organizations must be assured that the individual is keenly aware of the cultural implications that exist in the populations they serve. As mentioned earlier, this includes an

![Flowchart of Clinical Interpreting](image_url)
When it comes to interpreting, confidentiality becomes a double-edged sword.

understanding of a patient’s unique needs.

It is also important to note that languages may be the same, but dialect, country, or region of origin may vary. For example, the Spanish spoken by the Puerto Rican from New York is different than the Spanish spoken by the Hispanic in Los Angeles or San Antonio. Each population speaks Spanish, but word meanings may vary and speed and articulation are also factors.

Such dialect variations also have medical-legal concerns. For example, the Spanish word “siguru” means “maybe” or “no” for the Filipino. For an individual of Hispanic or Mexican descent, however, “siguru” means “sure.” It is therefore crucial that dialects are identified and intended meanings confirmed by the patient.

In addition to language subtleties, interpreters and translators must be competent in medical terminology, culturally aware/sensitive, and accurate in the actual interpreting and translating process. Competency in both roles may be verified through certification and or training.

Ethical Concerns

When using interpreters in a clinical setting the organization needs to be cognizant of certain items that can also be used in developing a code of ethics for their employees or contractors serving as interpreters. The following are the ethical principles specified by the California Healthcare Interpreters Association (CHIA):

- Confidentiality
- Impartiality
- Respect for individuals and their communities
- Professionalism and integrity
- Accuracy and completeness
- Cultural responsiveness (CHIA, 2002)

These principles are instrumental in assuring that interpreters are competent and that they are providing a service that expresses the thoughts and feelings of both patients and providers. Each of these tenets is focused on assuring the integrity of interaction between parties.

Legislative Mandates

In August 2000, Lizabeth Brott wrote the article “Policy Guidance on Discrimination Affecting Limited English Proficient Persons” for the U.S. Department of Health & Human Services. The article is an interpretation of Title VI of the Civil Rights Act of 1964 as it applies to organizations that receive federal funds.

Brott’s article emphasizes that facilities providing service to patients with limited English proficiency (LEP) need to focus on:

- Assessing the language needs of the potential patient population.
- Having a comprehensive written policy on language access.
- Ensuring staff understands the facility’s language assistance policy.
- Monitoring regularly to ensure that LEP patients have meaningful access to services (Brott, 2000).

Today, as we cope with the implications of the Health Insurance Portability and Accountability Act (HIPAA), we are particularly aware of patient confidentiality issues. When it comes to interpreting for those whose English is limited, confidentiality becomes a double-edge sword. The days of pulling in anyone (housekeepers, security, children, and or even strangers) with knowledge of the second language are going to become non-existent.

Problems and Pitfalls

The Office of Civil Rights (OCR) has identified certain items that may occur when interpreters are not readily available for patients with LEP:

- Substantial waiting periods to receive services.
- Patients required to make repeated visits to the provider until an interpreter is available.
- LEP patients often rely on minor children to interpret, or, alternatively, call upon neighbors or even strangers to interpret for them.
- OCR feels that these practices may have potential drawbacks and may violate Title VI of the Civil Rights Act of 1964 (Brott, 2000).

Flores, Laws, Mayo, Zuckerman, Medina, Abreu, and Hardt (2003) in their article “Errors in Medical Interpretation and their Potential Clinical Consequences in Pediatric Encounters” also identified certain problems when qualified interpreters were unavailable:

- Omission – did not interpret a word/phrase uttered by the clinician, parent, or child.
- Addition – added a word/phrase to the interpretation that was not uttered by the clinician, parent, or child.
- Substitution – substituted a word/phrase for a different word/phrase uttered by the clinician, parent, or child.
- Editorialization – provided his/her own personal views as the interpretation of a word/phrase uttered by the clinician, parent, or child.
- False fluency – used an incorrect word/phrase, or word/phrase that does not exist in that particular language (Flores, G. et al., 2003)

Competency

When addressing interpreter and translator competency, the following issues are important to consider:

What impact do interpreters and translators have on patient care outcomes?

- Increases understanding of medical condition and treatment.
- Decreases risks of adverse reaction of other medications and home remedies.
- Increases the patient’s ability to
explain symptoms or problems.
- Ensures accuracy of medical history.
- Increases compliance to provider’s prescribed treatment or advice.

Why is it important to validate the qualifications of interpreters and translators?
- Improves quality of care.
- Assures accuracy of information between patient and provider.
- Increases access to health care for individuals with limited English proficiency.

How are we responsible for assuring competency?

The health care organization is responsible for assuring interpreters’ and translators’ proficiency, similar to the responsibility for ensuring the skills of professional staff. This may be accomplished through various methods:
- Rating individual competency through oral and or written testing (written testing is usually considered the best).
- Identifying personal expertise (comfort level is important).
- Identifying a core group of individuals for each language and using certified interpreters first.

Conclusion

The concern with interpreting and translating services is whether an individual is competent to assist the patient and provider in exchanging information. Most medical and nursing programs don’t offer their students courses in languages that may be prevalent in the region in which they practice. Health care agencies are also reluctant to compensate individuals who are bilingual as it is usually an expectation that they will provide that service as part of their normal routine.

Interpreting and translating are like any other part of doing business: if the organization chooses to target a market that is culturally diversified, then this service becomes a crucial element of the business environment.

References

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New Eligibility Requirements for Ambulatory Care Nurse Certification

The American Nurses Credentialing Center (ANCC) Commission on Certification has announced new eligibility requirements effective for the October 2003 exam:

- Associate degree, diploma, baccalaureate, or higher degree in nursing.
- No core certification required.
- Hold a currently active RN license in the U.S. or its territories.
- Have functioned within the specialty scope of practice for a minimum of 2,000 hours within the last 2 years.

The exam consists of 100 questions in the following practice areas: clinical practice (25% of questions); communications (23%); client education (22%); issues and trends (16%); systems (14%).

Required Fees
ANA Member: . . . . . . . . . . . . . . $130
AAACN Member Discount: . . . . $180
Nonmember: . . . . . . . . . . . . . . . . $230

Please visit the ANCC Web site, www.nursecredentialing.org or call 1-800-274-4262 for more information.
A nurse’s head, heart, and hands are no longer sufficient tools to ensure quality care for our patients. Nurses must also use their voices to promote the health of our citizens (Smith, 2003).

To influence health care policy, we must start with a basic understanding of the legislative process. We shall begin with how a bill becomes law, identify the steps in the legislative process, and identify the points in the process at which we have the greatest opportunity to exert influence on our congressmen and women.

The United States Legislature is considered “bicameral,” or having two chambers, namely the House of Representatives and the Senate. For a bill to become law, it has to pass both chambers.

Bills start as ideas. The best bills are ones that are easy to explain and positively affect many people. (Source: www.yourcongress.com.) Anyone can draft a bill, however, only members of Congress can introduce legislation and by doing so become the bill’s sponsor(s). (Source: www.nursingworld.org.)

Before introducing a bill, a member of Congress will do research to collect facts and send draft versions to different organizations for their input on how it will affect their members. This is the first opportunity for citizens to influence a bill. Members of nursing organizations, when called upon to provide feedback, should take advantage of the opportunity to influence a bill at this stage of development.

Introducing the Bill

The official legislative process begins when a bill or resolution is signed by a member of Congress and placed in “the hopper” – a box on the floor. The bill is then printed and assigned a number (the number is preceded by “HR” to signify a House bill and “S” to denote a Senate bill).

There are four types of legislation:

- Bills
- Concurrent resolutions
- Joint resolutions
- Simple resolutions

Concurrent and joint resolutions are usually expressions of Congress’ opinion. Simple resolutions address internal House or Senate matters (www.yourcongress.com).

From Bill to Law

Step 1: A new bill is referred to a committee in the House or Senate depending on the chamber in which it originated. A bill can then be referred to a subcommittee or considered by the committee as a whole. There are three House and three Senate committees with jurisdiction over legislation affecting health care and health care professionals.

- Appropriations Committee – subcommittees are Labor; Health and Human Services; and Education.
- Energy and Commerce (Medicare Part B and Medicaid) – subcommittees are Health and Environment; and Hazardous Materials.

- Ways and Means Committee (Medicare Part A) – subcommittee is Health.

The Senate committees overseeing health care are:

- Appropriations Committee – subcommittees are Labor; Health and Human Services; and Education.
- Finance (Medicare) – subcommittee is Health Care.
- Health, Education, Labor, and Pensions Committee (H.E.L.P) – subcommittees are Aging; Children and Families; Employment Safety and Training; and Substance Abuse and Mental Health Services.

You can find listings and information on all congressional committees at www.senate.gov and www.house.gov.

It is important for nurses, grassroots organizations, and citizens to know which committee is handling a particular bill, as well as the chairperson and members of the com-
Bills can die due to lack of support. This is why it's crucial for nurses to wield their power and influence at key stages.

Step 2: Three things happen once a bill goes to a committee or is referred to a subcommittee: hearings, mark ups, and votes. Hearings are held to record the views of the supporters of the bill. “Mark up” is the process of making changes and amendments to the bill following the hearings and prior to recommending the bill to the full committee. Next the committee votes on its recommendation to the House or Senate. The hearings and “mark up” offer another opportunity for citizens and organizations to have input into the progress of a bill.

Step 3: When the bill is recommended to the House or Senate, a written report is prepared. This report describes the intent, scope, and impact of the legislation and includes the views of dissenting members of the committee.

Step 4: The bill is reported back to the originating chamber and is scheduled for floor action, which includes debate, approval of any amendments, and voting. At this point a bill is passed or defeated. When a bill is passed by the House or Senate, it is then referred to the other chamber where it usually follows the same process through committee and floor action. The second chamber can approve the bill as received, reject it, ignore it, or change it.

Step 5: If the second chamber makes significant changes to the bill, a conference committee is formed to reconcile the differences between the House and Senate versions. It is during this step that organizations and citizens have their last opportunity to influence the outcome by contacting the conference committee members. The House and Senate approved versions of the bill must be identical before they can be forwarded to the President.

Step 6: If the President approves the bill, he signs it and it becomes law. If he takes no action for 10 days while Congress is in session, the bill automatically becomes law. If the President vetoes the bill, Congress can override the veto with a two-thirds vote. Finally, if the President takes no action after Congress has adjourned its second session, it is a “pocket veto” and the legislation dies. (Source: N-STAT, 2003).

Conclusion

As you can see, the legislative process can be a daunting task with limited opportunities for input into the process. There is always the potential for a bill to die during each step for a variety of reasons. One reason is lack of support, which is why it is important for nurses to respond to calls for action when important health care legislation is pending.

The American Nurses Association (www.nursingworld.org) and the National Council of State Boards of Nursing (www.ncsbn.org) Web sites are excellent sources of information on pending legislation affecting health care and health care professionals. AAACN's Web site (www.aaacn.org) frequently highlights pending legislation that calls for nurses to take action and periodically sends broadcast e-mails urging members to contact their legislators to support measures important to ambulatory care nurses. AAACN was recently active in supporting the Nurse Reinvestment Act (HR 3487; S 1864), a bill sponsored by Congresswoman Lois Capps that addressed the nursing shortage. The bill was approved and signed into law on August 1, 2002 by President Bush.

Understanding the legislative process and knowing when to act helps nurses use their power and influence to affect a bill's outcome. Another crucial aspect of the process is lobbying; a topic that will be explored in the next installment of this series.

Reference


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AAACN Launches New Career Center

AAACN has added new career placement services to its Web site, www.aaacn.org. The AAACN Career Center offers a wide array of features that allow ambulatory care nurses to find a job or recruit employees.

Features for Job-seekers
The Career Center allows nurses looking for a job to:
• View jobs or post resumes free of charge.
• Post a resume confidentially or openly, depending on preference.
• Access hundreds of job listings locally, regionally, and nationally. Listings can be viewed 24 hours a day, 7 days a week, and are updated regularly. Options are offered for job searches in a wide variety of health care related areas.
• Track current and past activity.
• Manage a personal career profile on one page. The profile is easy to use and provides complete summary information all in one place.
• Send a cover letter with resume when responding to a job posting.
• Receive e-mail notification of new job postings.
• Access personal assistance, toll-free, 5 days a week.

Features for Employers
The Career Center offers the following features to employers or managers who are seeking to fill ambulatory care nursing positions:
• Access to a nationwide market of qualified ambulatory care nurse candidates.
• A ‘Resume Alert’ service that automatically delivers an e-mail notice when a potential candidate posts a resume.
• A ‘Job Alert’ feature that instantly notifies candidates of newly posted employment opportunities.
• Personal customer service and consultation throughout the contract term.
• Access to the resume databank and on-line tracking.
• Capability to search the resume database; edit a recruitment ad; add, delete, replace and archive filled position postings, maximizing recruitment dollars.
• Pricing for ambulatory care nursing positions starts at $195 per month.

The AAACN Career Center is a member of the HEALTHeCAREERS™ Network, an integrated network of 32 health care associations.

For more information, visit our Web site at www.aaacn.org and click “jobs,” or contact the Customer Care Center at 888-884-8242. You may also send an e-mail to info@healthecareers.com.
**AAACN Announces**

**Slate of Candidates**

The AAACN Nominating Committee is pleased to present the 2004 slate of candidates for upcoming election by the membership. These candidates are from varied and prestigious backgrounds and have agreed to devote their expertise to serving AAACN.

### President-elect

1 position

**Susan M. Paschke, MSN, RN,C, CNA**
Assistant Director, Office of Accreditation
Cleveland Clinic Foundation,
Cleveland, OH

**Regina C. Phillips, MSN, RN**
Process Manager Delegation Compliance Department
Humana, Inc., Chicago, IL

### Board of Directors

3 positions

**Carol A. B. Andrews, BSN, MS, RN, CNA, BC**
Deputy Chief Nurse, 48th Medical Group
U.S. Air Force
RAF Lakenheath England

**Kari J. Hite, RN, CDE**
Quality Management RN
Southern Arizona VA Healthcare System, Tucson, AZ

**Anita Markovich, MSN, RN, MPA, CPHQ**
Director, Quality Services Division
Our Lady of Lourdes Memorial Hospital, Inc.
Binghamton, NY

**Sara M. Marks, CDR, NC, USN**
Program Manager, Health Service Support Doctrine
United States Navy, Newport, RI

**Kitty Shulman, MSN, RN, C**
Director, Children’s Specialty Center
St. Luke’s Regional Medical Center
Boise, ID

**Beth Ann Swan, PhD, CRNP**
Associate Director, Office of International Programs & World Health Organization (WHO)
Collaborating Center for Nursing and Midwifery Leadership
University of Pennsylvania School of Nursing, Philadelphia, PA

**Charlene Williams, MBA, BSN, RN, BC**
Manager, Nurse on Call
Cleveland Clinic Foundation,
Cleveland, OH

### Nominating Committee

1 position

**Pamela Del Monte, MS, RN, C**
Clinical Director for Primary Care Veterans Affairs Medical Center
Washington, DC

**Cynthia Pacek, MBA, RN, CNA**
Clinical Trial Coordinator
New England Regional Headache Center
Worcester, MA

**Christine M. Ruygrok, RN, MBA**
Director, Clinical Strategy Consulting Department
Southern California Permanente Medical Group
Kaiser Permanente
Pasadena, CA

The September/October 2003 issue of Viewpoint will include the candidates’ biographies and statements. A ballot will be mailed to all AAACN members in November 2003.

**Candia Baker Laughlin, MS, RN,C**
Nominating Committee Chair
candial@umich.edu

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**AAACN Member-Get-A-Member Campaign**

The AAACN Member-Get-a-Member campaign kicked off on April 13, with Carol Rutenberg leading the contest with three recruits so far.

If you are a AAACN member, there is still plenty of time for you to win **paid registration, airfare, and lodging** for the 2004 Annual Conference in Phoenix (March 18-22, 2004) if you recruit six or more members.

You can also win a certificate worth $100 off programs or products by recruiting three or more members. To qualify, make sure the colleagues you recruit fill in your name on the “Who referred you to AAACN?” section of the membership application. Make sure they join before December 31, 2003. Visit [www.aaacn.org](http://www.aaacn.org) for more details.

**Welcome to Our New Members**

AAACN is pleased to introduce our new members from this program. We thank their sponsors for their recruitment efforts:

- Monica Bradford, Agana Heights, GU; Deborah Davis, Houston, TX; Marguerite Donius, Watsonville, CA; Marilyn Duey, Longmont, CO; Roberta A. Hanrahan, Galveston, TX; Barbara Jessup, Gaithersburg, MD; Jodie Linard, Kansas City, MO; Sherry Lynch, Oshkosh, WI; Brenda Morgan, Centerville, OH; Kay Powell, Syracuse, NY; Maryellen D. Priebe, North Haven, CT; Patricia H. Robison, Shelton, CT; Barbara L. Smith, APO, AE; Elizabeth Tanner, Wakefield, RI; Janet M. Thomas, Laconia, NH; Kiley E. Walker, Minneapolis, MN; and Judy A. Young, Melbourne, FL.

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**www.aaacn.org**

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AAACN Board Meets in June, Explores Key Issues

The 2003-2004 AAACN Board of Directors held its summer meeting June 27-29 at the National Office in Pitman, NJ, and at the home of Beth Ann Swan, AAACN secretary, in Rydal, PA.

During the meeting, the board previewed upgrades to the AAACN Web site, www.aaacn.org; discussed the association's staffing survey; reviewed the blueprint for the 2004 Annual Conference with Education Director Sally Russell; discussed future marketing efforts with Marketing Manager Tom Greene; and approved new online courses on Bloodborne Pathogens and HIPAA Compliance.

The board also reviewed and approved the 2003-2004 budget, renewed a 5-year contract with Anthony J. Jannetti, Inc. for management services thru December 2008, and discussed the results of an ongoing AAACN Membership Scan that gauges member feedback on key issues and AAACN services.

The board also outlined the critical issues to be addressed during the next several years (see “From the President,” page 2, for more on these issues.)

AAACN Revising Two Standards Publications

The AAACN Ambulatory Care Nursing Administration and Practice Standards and the AAACN Telehealth Nursing Practice Administration and Practice Standards are currently being reviewed and revised.

The new editions are expected to be available at the 2004 AAACN Annual Conference in Phoenix, AZ, March 18-22, 2004.

Janet P. Moye, RN, MS is chairing the two teams. Members of the revision team for the Administration Standards are Betty Cody, Deb Haagenson, and Cynthia Pacek. The Telehealth Standards will be reviewed and revised by Sydney Youngerman-Cole, Tania Herr, and Carol Rutenberg. AAACN members are welcome to send their standards recommendations for consideration to Janet Moye at moyej@mail.ecu.edu.

Welcome to AAACN Staff

Simone Strouble was hired as AAACN’s new Fulfillment/Information Services (FIS) coordinator on July 7, 2003. Simone will be working closely with AAACN Association Services Manager Pat Reichart to coordinate membership and registration processing, order fulfillment, and other database services.

Simone recently located to Glassboro, NJ, from Boston, MA, with her 2-year-old daughter, Journey. Prior to her arrival at AJJ, Inc., Simone worked at Brigham and Women’s Hospital in Boston in the Fertility and Endocrinology Department.

While not new to the health care industry, Simone is excited about joining the AAACN team. We wish her the best of luck in her new job!
Nursing Leadership
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es. Stand-up comedians include them in their acts because
the inherent irony in an oxymoron is good for a quick laugh.
Given the continuing crisis state of the health care indus-
try, will “nursing leadership” become the newest oxymoron?
To avoid this dubious distinction, nursing leaders must
take stock of what they are currently doing and redirect their
energy as well as the energy of their staff members. But
achieving this shift in awareness, attention, and action
requires a brief examination of the factors influencing the
dynamics of nursing leadership.

The Evolution of Nursing: Nature and Nurture

Nursing struggled with its professional identity long
before Florence Nightingale arrived on the scene. In ancient
Egypt, for example, slaves served as nurses, a stigma still sub-
tly felt by Egyptian women who choose nursing as their pro-
fession. The situation was not much better in Florence
Nightingale’s time when hospitals were squalid places and
nurses were women who were not only untrained, but also
often inebriated women of ill repute (Pulliam, 2003).

Based on her efforts and the efforts of the women who
worked with her to provide aid and comfort to wounded sol-
diers during the Crimean War, Florence Nightingale became
the icon for nursing – the individual recognized for elevating
nursing to professional status. This rise in status, however,
was not without cost. British military doctors did not wel-
come Florence and her compatriots; yet despite this hostility,
she pushed on toward her goals to organize the care of the
wounded and keep the field hospitals clean as a way to
decrease unnecessary deaths.

Thus nursing as a profession was born in the social con-
text of war, complete with its paternalistic, military hierarchy,
within a society whose defining characteristic was, and still is
to a great extent, a class system. The nature of a highly femi-
nized profession emerged and was nurtured and shaped by
the values (for better and worse) of its dominant male cul-
ture. Is it any wonder that struggling to find not only its
voice, but its strength, is almost a part of nursing’s DNA?

Learned Incapacity: The Cultural Impact

The influence that culture exerts on nursing leadership
has created a set of unspoken assumptions about the func-
tioning and dynamics of nursing and nursing leadership.
Whether its source is societal, organizational, or professional,
culture shapes the assumptions, beliefs, behaviors, and
actions of those who live and work within it (Schein, 1997).
In the case of nursing leadership, these cultural sources have
worked in concert to compound their influence and tacitly
shape expectations and behavior. Consider the following
story as a metaphor for the evolution of nursing leadership:

The average elephant weighs 16,500 pounds.
Elephants are still used as beasts of burden in Africa and
India. How are these massive creatures domesticated? Why
don’t these animals break free from their captors? How is it
that they are tamed and their strength and energies are
harnessed? You would be surprised.

Young elephants are captured and separated from their
mothers. A large, heavy rope or chain is attached to one of
the animal’s legs; the other end is secured to a huge tree.
The baby elephant fights to break free but cannot move
very far; its leg is tied to the tree. Over time, the elephant
learns it can’t break free and begins to struggle less. As the
elephant becomes more docile, the massive rope around its
leg is replaced with successively lighter weight ropes and
these lighter ropes are secured to smaller and smaller trees.

As the elephant learns that it cannot break free and
increasingly lighter weight ropes are secured to smaller
trees, then small logs, the elephant “forgets” its strength
and power. Eventually, the now mature, 8-ton elephant
remains in place, tethered to a stick no bigger than your
forearm by a rope the weight of an average dog’s leash.
How can this be? The elephant learned to be incapacitated
– unable to move or use its strength.

The same loss of might could be said about nursing
leadership. The class system and the cultural values have
been, metaphorically speaking, the rope and tree that have
tethered the nursing profession, working hand in glove to
incapacitate a powerful force. In some respects, nursing lead-
ership has become debilitated by the organizational context
in which it finds itself and must regain its strength in order to
become a force to be reckoned with.

From Tactical to Strategic Focus

To regain nursing leadership’s strength, nursing leaders
need to take a hard, objective look at what they are doing
on the job. They can begin by answering this question: “On
a weekly basis, what percentage of time do I spend putting
out brush fires?” Leaders who spend more than 15% of their
time dealing with crises – that is approximately 9 hours out
of a 60-hour workweek – need to make a change. When
nursing executives are responding to crises they are not lead-
ing.

Next question: How many of these brush fires does nurs-
ing actually own or are we functioning as the organizational
“mop squad?”

One could argue that it’s hard to know where a “nurs-
ing” issue begins and ends but that is precisely the point.
Because the basic mission or task of health care delivery
Interdependencies in health care delivery explain why nursing will never be able to “fix” the problems inevitably traced back to nursing.

requires a high degree of interdependency within the organization, problems are more likely to be systemic vs. divisional, departmental, or individual problems.

According to Russell Ackoff (1974), the nature of a system is that it consists of two or more elements, with each element having an effect on the whole. The elements in a system are interdependent and while the elements may reorganize themselves into a variety of subgroups, the subgroups will still be characterized by these properties:

1. Each has an effect on the whole.
2. No group has an independent state.

Not only does this describe the dynamics of health care delivery, it also sheds light on why so many re-engineering initiatives within nursing either failed or were fraught with problems. From a systems perspective, the entire health care delivery system would require re-engineering, not just nursing. Simply reengineering nursing turns a blind eye to the realities of interdependencies of health care delivery. Despite this knowledge, nursing is almost always considered either the source or the solution to problems within a health care organization.

Part of the difficulty arises from the nature of nursing itself. Nurses have primarily learned to respond to here-and-now stimuli – a patient in pain, checking clinical and vital signs, etc. In essence, years of clinical experience hone what would be referred to in business parlance as tactical skills. Compounding this is the culture of many health care organizations, which is characterized by responding to immediate and emergent issues.

Thus, leaders who have been practicing nurses are further reinforced to do what they know best. The press of the organizational culture pushes a nurse executive to address short-term emergencies at the expense of determining and following a long-term, strategic direction.

Therefore, in health care as in other industries, when bright, high-achieving, individual contributors are promoted to management and leadership positions, these individuals do what they do best: focus on daily operations or tactical issues.

At the management level, it is appropriate to focus on the tactical issues. However, if nursing executives stay in their comfort zone of the familiar hands-on daily operations, they will be giving short shrift to one of the key elements of their leadership role – strategic focus. And their nursing staff will pay the price for this crisis-management orientation, even if the nurse executive does not generate but merely responds to crises out of habit.

This is not to say that crises should go unaddressed. On the contrary, crises must be dealt with effectively and efficiently to ensure the well being of patients and to maintain quality and positive outcomes. The real challenge facing nursing executives is two-fold:

- Developing the proper “bench-strength” among direct reports so they can be deployed to problem-solve at the lowest appropriate level within the organization.
- Adopting a systems approach to change.

These two areas of focus form the foundation for a nursing leader to create and sustain a strategic focus; in essence, they address daily operating issues in such a way that they “buy time” for the nursing executive to focus on strategic goals.

Bench Strength: Savvy Leader’s Best Friend

Borrowing a concept from sports and applying it to nursing, bench strength simply means that the nurse leader’s “players” are versatile enough to be used in several different positions and “cross-trained” to be effective substitutes when called upon to fill in.

In business, bench strength is linked to strategy in that it provides a contingency plan to keep on with “business as usual” when life throws a curve ball, or more realistically, when your valued staff members become ill, take vacation, or accept a job in a different department or organization. No leader should ever allow a solitary staff member to be the only individual who knows, understands, or manages information or processes that are vital to organizational functioning. Nor should a leader tolerate projects being put on hold, decisions being delayed or problems going unsolved because a key staff member is on vacation or unavailable.

Savvy leaders insist on bench strength to provide backup.

To develop bench strength, begin with your direct reports. First, reassess their core competencies to ensure that they can effectively and efficiently handle crises, speaking and acting competently as your agent. To effectively assess your direct reports, forego the checklist approach that has become such a popular and timesaving, albeit questionable, mechanism for “assessing” competencies.

That being said, you should still list the skills, abilities, and knowledge that you consider essential for your staff to demonstrate if they are to speak and act on your behalf when tactical issues are raised. Prioritize the list from most to least critical. Use the list as a reference guide when you both observe your staff exhibiting behavior-based competencies and provide them with feedback regarding their performance.

For example, replace the all-inclusive “Communicates effectively” with the more behaviorally based “Effectively uses active listening by:”

1. Accurately identifying the emotional and content message delivered by sender
2. Paraphrasing the ‘heard’ message to the sender
3. Responding appropriately and effectively to the sender’s feedback about the paraphrased message

Generally speaking, nurse executives wishing to focus more on the strategic and less on the tactical should focus on compe-
Taking a Systems Approach

Many of the problems facing today’s nurse executives are the result of bringing problems apart into smaller and smaller units of analysis in the hope of finding “what is wrong” and fixing it when in reality “what is wrong” has more to do with the failure to emphasize and improve the interdependency which is at the core of all systems. Thus, addressing a “nursing” issue can be an exercise in futility. Situations that are labeled, as “nursing issues” are often circumstances in which the failure of the interdependencies becomes apparent because the buck stops, so to speak, with nursing.

Nursing executives who embrace a systems approach will be less likely to assume ownership for problems without first encouraging their colleagues to look at the issue within its context. This may mean exploring the impact of physician behavior on the problem. It may mean pushing to include physician practice patterns as part of a solution. It may mean gaining insight into the need for consistency from leadership throughout the organization. It might be just the thing to successfully leverage the argument that the survival of a healthcare organization rests with ability of its leaders to for-sake old, ineffective and mindless patterns of affixing blame for problems and take on the challenge of understanding how to make things work more effectively and efficiently.

Putting it All Together: Act ‘Thinkingly’

To make the shift from tactical to strategic focus, nurse executives must realize that they, as “…people in organizations should be more self-conscious about and spend more time reflecting on the actual things they do” (Weick, 1979, p. 168). In essence, they need to act ‘thinkingly.’ No, this isn’t another oxymoron; it is an acknowledgment that we create our own environments. Weick, paraphrasing Braybrooke, captures the notion of the enactment of experience this way:

“Experience is the consequence of activity. The manager literally wades into the swarm of “events” that surround him and actively tries to unrandomize them and impose some order. The manager acts physically in the environment, attends to some of it, ignores most of it, talks to other people about what they see and are doing.” (Weick, 1979, p.148)

In essence, what we do at work (our actions) actually shapes the organization’s environment. Thus, if nurse executives actually do more tactical than strategic things, then the reactive crisis mode will be their reality. Combining reflection

Nursing leaders often focus the bulk of their time and attention on inpatient nursing and assume that ambulatory nursing will take care of itself.
with action will impact the organizational environment by shaping it in a different way. Shifting to a future focus and aligning actions with that future state, nursing leaders will begin to move out of the tactical and into the much needed strategic focus. Balancing action with reflection modulates nursing executives’ penchant for action with the necessity of being mindful or thoughtful.

To act thinkingly is to move out of the reactive, tactical response mode and focus on the bigger picture. It is the key to making the transition from the tactical to the strategic. In order to accomplish this, a nursing executive should be able to clearly articulate her/his responses to the following questions:

- What is my strategic focus for nursing within our organization?
- What are my strategic goals?
- How do I measure progress toward these goals?
- How do I keep my strategic goals in the forefront of my primary organizational interactions?

In simplest terms, a strategic focus should identify an ideal state in light of the current existing state. Perhaps you want to be the employer of choice in your area. Maybe you want to promote nursing research that reflects innovative care techniques. Whatever the focus, it should take into consideration from both a business and people perspective what “could be.” Stronger nurse-physician partnerships, more cost-effective care delivery, reduced waste, increased efficiency, more satisfied staff, or higher retention rates – a strategic focus considers the context in which your organization exists and aims at creating that distinctive difference which promotes organizational health.

Once a strategic focus is clear, developing strategic goals is the next task. To simplify what can appear an odious task, use the back-planning model. Back-planning is merely a method of starting with the end result, in this case the strategic focus, and working back from that point toward the current state. Think of the steps involved in planning a Thanksgiving dinner. If dinner is to be served at 6 pm, what is the next step back? In this case it would mean taking the thoroughly cooked turkey out of the oven at 5:45 pm to rest before carving. The next step back would involve cooking time, which would be contingent upon the weight of the turkey. Next step back? Thawing the turkey. Don’t know enough about cooking a turkey to make a realistic plan? Then talk to seasoned experts and learn. Ultimately, the plan for Thanksgiving dinner would develop as a timeline of critical incidents, actions, and outcomes.

Some leaders’ strategic goals incorporate measurements, others require an additional step to ensure that there is some valid way to measure progress and outcomes. In either case, the measurements are the mechanism to both stay focused and stimulate action. Maintaining a strategic focus in a reactive environment is a struggle. However, nursing leaders must devise ways to keep their attention trained on their strategic goals.

One exceptionally high-impact health care executive maintained his strategic focus on improving customer service in this way: he kept his desk clear and under the protective glass desk topper he inserted two signs, both with the same message. One sign faced him; the other faced whoever was sitting opposite him at his desk. The sign read simply: “If you’re not serving the customer, you’d better be serving someone who is.” This was his mantra, so to speak, that kept him focused before, during and after his interactions with others. He made sure that each of his exchanges with staff and employees incorporated some aspect of customer service, whether it was the service standards he modeled through his behavior, a clear organizational strategy to improve service, or a change in organizational policy that would affect employee morale, subsequently having an impact on customer service.

Conclusion

Nursing leaders can leverage significant change within their organizations – if they choose to break free of the cultural expectations and habitual behaviors that often chain them to unsatisfying, grinding work. As nursing leaders assert themselves and leverage their sense-making abilities to inject a worldview that honors interdependencies, they will more clearly recognize how they shape their reality. And as nursing leaders stretch their personal comfort zones they will begin to shape the reality of their staffers as well. Imagine an organization in which:

“...Endless discussion of questions about whether we see things the way they really are, whether we are right, or whether something is true will be replaced by discussions that can focus on questions such as ‘What did we do?’ ‘What senses can we make of those actions?’ ‘What next steps best preserves our options and does least damage to our repertoire...’”

(Weick, 1979, p. 169).

As nurse executives take on the challenge of saying “no” to crisis management, elevate their business acumen, and focus energy on their strategic goals, nursing leadership will, in fact, become a force to be reckoned with.

References


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From the President
continued from page 2

Critical Question 2: How can we articulate a strategy to achieve and maintain financial stability within the next 3 years?

We know we have some challenges in this area. We also know we are beginning to evolve the framework for some creative answers. Our goal is to increase our membership and boost our number of corporate sponsors: individual, business/vendor, and employer.

Our initial ideas include the following:
• Develop the concept of organization (e.g. employers) members. Early discussion leads us to believe we could offer an attractive array of benefits to organization members that might include bulk purchase rates for our standards and other products; reduced membership for the employer’s ambulatory care nurses; access to our Web site Member’s Only section, consultant/speakers bureau, and legislative updates.
• Offer our organization members the opportunity to place recruitment ads for their facility on the AAACN Web site. The ads would have a direct link back to the organization’s site. This would be an advantage for our members as well as for employers in general.
• Work closely with the AAACN Membership Committee to devise effective strategies for attracting and retaining members.

Critical Question 3: How do we establish meaningful connectivity between the national organization and our grassroots members?

There are many issues to address as we approach the answers to this question. Here are just a few considerations:
• Do we want to have regional or local conferences in addition to the annual conference? If so, how would we go about engaging regional or local members to help?
• Do we want to continue with our local networking groups? Do we want to have regional networking groups? If the answer is “yes,” how can we foster the evolution and viability of these groups? The issue is not so much whether we have different kinds of groups, but rather what would be of greatest value to our members? What would engage them and excite them about being more involved in their professional organization?
• If we have regional or local networking groups (or both), could they consist of both AAACN members and non-members?
• How do we create an organizational environment that meets the needs of four generations of members?

Let Us Know Your Opinion

As you can see, our plates are full but our work is exciting. We need your help to better define the answers to our questions. Please contact us with your thoughts and ideas (phone 1-800-AMB-NURS or e-mail aaacn@ajj.com). Let us know about individual vendors who may be interested in a AAACN corporate membership. Or, let us know if your employer might be interested in an organization membership.

We will strive to find creative answers to each of the three critical questions. However, our answers will be better and more applicable to our current membership base if you join us in finding our next best steps. Thank you for your ongoing help, support, and participation.

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AAACN 29th Annual Conference
March 18-22, 2004 • Phoenix, AZ

The theme for the AAACN 2004 Annual Conference is “Forging New Partners and Championing Change.” This year’s conference will put the spotlight on the creative and innovative methods being used by our colleagues in the ambulatory care setting.

The planning committee is currently finalizing conference content, and working with speakers and the AAACN Board of Directors to ensure that presentations are focused on the most valuable topics. Over 65 outstanding abstracts were submitted, which provides a challenge to the planning committee as all cannot be chosen.

The sessions that have been confirmed are varied both in content and focus. There will be a session devoted to emergency preparedness, a second describing the Toronto experience with SARS, while another will look at risk identification and reduction in ambulatory nursing clinics. Latex Barrier protection and the concerns surrounding latex will also be discussed.

Several clinical sessions are planned and include sessions on blood pressure control, managing acute asthma in children, and acupuncture and alternative medicine.

International nursing concerns will be evident as well, with sessions on patient liaison nurses in Middle Eastern teaching hospitals and ambulatory care nursing in deployed locations. Cultural diversity issues, an important topic for those in ambulatory care, will also be highlighted. Leadership topics, such as managing effective meetings, the art of negotiation, mentoring, and the ever-present concerns of JCAHO and HIPAA, are featured throughout the conference.

As in previous years, there will be several innovative “Special Sessions,” plenty of networking opportunities, and the opportunity to meet colleagues with common interests during the Special Interest Group sessions.

Please visit www.aaacn.org and check upcoming issues of Viewpoint for more information on AAACN’s 2004 Annual Conference.

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AAACN welcomes our new Corporate Member and thanks LVM Systems, Inc.!

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(480) 633-8200 • Web site: www.lvmsystems.com

LVM Systems, Inc. was founded in 1988, and has served the health care industry for 15 years. The company:
• Develops and markets software products exclusively in the health care industry
• Has over 16 years experience exclusively in health care software development
• Has over 25 years experience in software development
• Provides on-site training, phone support, network consultation, custom screens, and custom reports
• Was the first company to introduce Microsoft Windows technology for health care/physician services market

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www.hmsnorthwest.com

Corporate Spotlight
AAACN would like to welcome our newest Corporate Member for 2003. LVM Systems, Inc. joins our other Corporate Members by generously contributing funds to provide quality services to our membership.

Advance the art and science of ambulatory care nursing