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Nursing leadership

A report of an international seminar
organised by the
King Edward's Hospital Fund for London
and the Royal College of Nursing

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Nursing leadership

A REPORT OF AN INTERNATIONAL SEMINAR ORGANISED BY THE KING EDWARD'S HOSPITAL FUND FOR LONDON AND THE ROYAL COLLEGE OF NURSING

HELD AT
KING'S FUND COLLEGE, PALACE COURT
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FOREWORD

The seminar reported in this paper was the fourth of its kind held at the King's Fund College. It was organised jointly with the Royal College of Nursing whose general secretary, Trevor Clay, had suggested that a small number of European nurses holding positions of authority might examine the question of nursing leadership in an international context. He thought they might become a peer group able to discuss problems of leadership – and the related questions of power and politics – in a climate of trust, mutual understanding and respect.

The ideas explored concentrated upon the mix of accountability, leadership and power in nursing as it relates to society. Ways of using power creatively to bring about change and/or improved relationships with others to influence the quality of care, were examined in some detail: for example, can the nurse manager be accountable for quality patient care with decreasing human and natural resources, and within the context of changing value systems and cultural expectations? The complexity of the subject became obvious as questions were asked; it also became clear that the answers needed to be sufficiently flexible to take account of the future. Instant answers were impossible, but the discussions highlighted the importance of the process of forming ideas which could lead to ways of approaching change, and providing some answers.

Membership of the seminar was kept small deliberately. Discussion was self-generated. It is difficult to capture the characteristic quality of such an exchange, but Baroness Cox, acting as discussant, has succeeded.

It is hoped that the seminar provided ways of establishing new contacts and strengthening old ties, and helped to produce new ideas for emerging nurse leaders whose main task will be to improve the quality of health for the people in their care.

Hazel O. Allen
Associate director
King's Fund Centre

INTRODUCTION

In the autumn of 1984 an international seminar on nursing leadership was held at the King's Fund College in London. The conference was organised by Miss Hazel Allen of the King's Fund and Miss Margaret Green of the Royal College of Nursing, after preliminary discussions between senior British nurses and the Fund. It was decided that the membership of the seminar should be widely spread throughout Europe, among nurses able to speak with authority about their own health care system and holding a position of some responsibility within it. The focus would be on issues of major concern to such nurses, particularly on the ways in which nurses influence (or fail to influence) the political and other decisions that determine levels of expenditure and patterns of service. Essentially, therefore, the seminar was about nurses and power.

Representatives of thirteen countries had accepted invitations to attend, together with the Senior Scientist for Nursing, Division of Health Manpower Development, World Health Organization Headquarters, the Executive Director of the International Council of Nurses and the Officer for Nursing, European Regional Office of the World Health Organization. (See Appendix II for a full list of participants.)

In his welcoming address, Dr Robert Maxwell, Secretary of the King's Fund, recalled his meeting with British nurses at the preliminary discussions and expressed his pleasure in attending the realisation of their choice. After extending a very warm welcome on behalf of the King's Fund to all participants, Robert Maxwell spoke of leadership in the wider health care field. He suggested, as James Thurber had, that 'it is better to know some of the questions than to know all the answers', and took the opportunity to present to participants a few of his own propositions and questions.

Health care needs and possibilities, he said, were increasing faster than the resources to meet them. Consequently, controlling the growth of expenditures would continue to be a major national concern everywhere. (Here Robert Maxwell recalled Valéry's observation that 'the only trouble with our time is that the future is not what it used to be!') Because governments were concerned primarily about health care expenditures that were government-funded, expenditure constraints would be tightest in public health care systems and especially those that were funded from taxation rather than from social security, and those that were financed centrally rather than locally. Robert Maxwell prophesied that there would be continuing efforts by governments to shift the burden of health care

expenditures to others, including consumers and the private sector, and that health policy was likely to be increasingly politicised. Moreover, he believed that there was a danger that the gap between standards for the fortunate and for the unfortunate would widen.

Leadership, he said, was partly about power and partly about charisma, but it was by no means solely about those two qualities. It also had to do with (for example), breadth, relevance and coherence of vision; the ability to communicate that vision; picking good people to work with and helping them to grow; sticking to essentials and the willingness to make mistakes (but not too many nor too big!). Leadership in the health care field had both professional and corporate dimensions which had to mesh. Often they did not do so very well.

Posing questions to the group, Robert Maxwell asked them: 'What should leadership in nursing entail?'
'Is there anything amiss in the current management arrangements?'
'Should clinical autonomy rest closer to the front-line structure of clinical care than many nursing structures and management processes recognise? If so, how does this alter leadership roles and preparation for them?'
'Why are patient care, education and management so separate in terms of nursing career paths? Should they be more closely integrated? If so, how can this be achieved?'
'Why is it that many senior nurse managers fall back on a rather narrow view of their role and responsibility?'
For example, he said, they were often possessive about 'nursing issues'; were sometimes sentimental about their own role (perhaps because 'hands-on' patient care is what nurses are loved for, but is not what senior nurse managers do); and were frequently insecure in venturing out to the corporate management issues, possibly because they lacked confidence in some of the skills required.

Lastly, he asked: 'Can nurses contribute to cracking some of the major management issues in the health care system? For example, finding practical ways to assess and promote the quality of patient care; making the system more responsive to what people want and what they think; and finding new, imaginative approaches to the delivery of care that are more humane and more cost-effective than the old?'

It was to these and other vital questions now being asked in the wider health care field, Robert Maxwell said, that he hoped participants would address themselves during the seminar. He believed the chosen topic to be one of major importance and wished participants success in their forthcoming deliberations.

ACCOUNTABILITY, LEADERSHIP AND NURSING

Miss Sheila Quinn, CBE, President of the Royal College of Nursing welcomed participants on behalf of the College and introduced the key-note speaker, Dr Shirley Chater, Council associate, Division of Academic Affairs and Institutional Relations, American Council on Education, Washington, DC.

Introduction

This is an anxiety provoking time for nursing. Respective efforts of our countries to contain costs of health care and to experiment with the means to do so, give rise to our fears that nursing, too, will inevitably be affected. Both the private and the public sectors are undergoing rapid changes to accommodate spiralling costs, changes in population groupings, and inflation. Meanwhile, consumers continue to expect the highest level of care and quality of life throughout this period of upheaval, and nursing has no choice but to oppose medical cost-cutting strategies that adversely affect quality patient care.

It is against this backdrop of social and economic concerns that this International Seminar on Nursing Leadership convenes. Our group represents historical and cultural diversity. At the same time, many of the social and economic variables with which we have to deal in relation to health and nursing care are similar enough to allow us to make some generalisations that may stimulate problem solutions for some of us and problem identification for others. In any event, we have the opportunity, during these four days together, to share our concerns, enumerate our anxieties, express our ideals and plan strategies for implementing change at home.

For my part of this agenda, I want to share with you some ideas about *accountability*. We all believe that nurse managers and leaders must be accountable for the highest possible quality of care, but we worry that the 'crisis' in health care financing may affect our ability to retain that accountability.

Later in the programme, Trevor Clay will remind us that nurses must play an increasingly large *political* role in determining and implementing policy that, in turn, legitimises all for which we want to be accountable.

Later, Martha Quivey, from her perspective as a director of nursing services, will discuss conflict management. She notes that possible conflicts exist within the nurse manager (or leader) herself, between the

nurse manager and other staff and among non-nursing colleagues. She will suggest also an overlay in our work of professional versus bureaucratic role conflicts.

I hope that our discussions will shed some light on the issue of accountability during these difficult and anxious times. Certainly, our exchange of information will cause us to focus upon our own individual roles in leadership positions and to consider what we might do to address the substance of the conference on leadership.

Accountability

Management literature speaks regularly about responsibility, decision making and other acts of leadership. The concept of accountability is less well described and less well illustrated by example. So that we all have a common ground from which to speak today, I submit that accountability is a singularly most important *management act* – an executive function imbedded in value systems and cultural expectations. Accountability involves others' expectations of one's behaviour. It is not only product or outcome oriented, it is process oriented as well.[1] Therefore, in nursing, we feel not only accountable for high quality care (an outcome), but we feel accountable also for the process by which the outcome of care was reached. Because accountability is imbedded in value systems and cultural expectations, the standards of accountability may change over time as value systems and cultural expectations change.

To distinguish accountability from responsibility, we can say that responsibility is much more specific because it is more task oriented. Responsibility is one's obligation to perform. Accountability implies that one's actual performance will be judged against performance expectations or standards. Accountability is also different in scope. It supersedes responsibility. In general, it is nurse leaders who are accountable for the delivery of nursing services while staff nurses and others are responsible for the tasks and actions that comprise patient care.

A second most important characteristic about the concept of accountability is that one can only be accountable within the constraints of the human and material resources available.

Herein lies the problem posed by the title of today's seminar: can nurse leaders be accountable for high quality patient care within the present constraints of human and material resources available to us and within the context of current value systems and cultural expectations? The answer is yes. We must. We will. It is our goal to do so. But it is a goal fraught with difficulty and frustration.

Aaron and Schwartz help us to gain some insight into what will happen

if budget limits are sustained.[2] Their research examines how physicians in the British health care system treat ten important medical diagnoses and procedures. It is, at best, unsettling and distressing to note the effects of reduced resources, together with perceived changes in social values and expectations regarding the medical problems described (problems relating to dialysis and kidney transplantation, haemophilia, cancer chemotherapy and radiotherapy, to name a few). Aptly enough, their small book is entitled *The painful prescription: rationing hospital care.* The authors illustrate what happens when both variables of accountability change; when resources decrease and the value systems and cultural expectations about who to treat, when and how, also change.

Lest we become too harsh in our criticism of the *painful prescription*, we can examine realistically and honestly our own participation in the process of rationing patient care. Each of us will be able to recall situations in our own nursing practice when it was literally impossible to attend to the needs of two patients simultaneously, and we were forced to choose which had the higher priority. This was a kind of rationing, even though we rationalised our choice through the socially acceptable exercise of 'semantic massage' and called it 'priority setting'. We are also familiar with other forms of rationing patient care. Sometimes it is by economic means, (that is, potential patients who cannot pay for it, do not receive it). Sometimes it is by access means (that is, the technology or health care provider is not available locally).

On a somewhat lighter note, one example comes to mind from my very early experience at St Bartholemew's Hospital here in London. My 20 year old recollection of how fluids were administered to patients direct from surgery consists of Bart's nurses, trim in uniform, wearing elegant silver belt buckles, standing by the patient's bedside, cup of tea in hand, in order to allow teaspoon by teaspoon of tea to slip slowly and warmly between dry and thirsty lips. Infinite patience. Ultimate care. Beautifully effective but undoubtedly inefficient. The humanitarian aspect of tea by the teaspoon gave way to the new technology and the quickly accepted principle of intravenous feeding, because, perhaps, of decreasing resources (nursing time), but definitely because of changing values and expectations (efficiency). In this example, accountability was retained despite changes in the variables we have been discussing.

What remains of the 1980s will continue to challenge us in ways that as yet we do not fully realise. The cost containment method of implicit rationing of care will require a new ordering of priorities.[3] We will be called upon to make 'trade-offs' and to exercise delicate balancing acts if nursing is to retain control of its own destiny.

I believe we would all agree that we have no choice but to make known our strongly held views, our values, ideals and commitments relating to quality care and quality life for our clients. Our commitment to the prevention of disease and promotion of health is strong. We simply must not allow our ideals to come into conflict with trends within the larger health care delivery system.

But we cannot just passively hope; we must become active as never before, in overall health care planning. Nurses must have a voice in determining their future responsibilities to the people. How else can we assure our accountability?

The creative use of power

The contest for power emerges not from an abundance of resources, but from the scarcity of them. Power means 'to be able'. Power is present in every work situation. It seems obvious that we utilise power in 'enabling' ways to achieve the goals and objectives that we set for ourselves to assure our place in planning for nursing's future.

Power as a concept has been badly treated. If one thinks of it in its original meaning of 'to be able', its negative image changes to a positive one and we, as nurse leaders, can put it to creative uses. Further, power can be viewed as existing in unlimited quantities: it is not a finite unit. When one uses power or gives it to someone else, it is not used up or finished. It can be created anew and incorporated into the work setting as a management strategy.

The authority to use power is invested in each of us in a variety of ways. First, there are formal, legal, legitimate sources of power. Our licence to practice is one form of authority. The power we derive from the position or title of our jobs is another. There are also informal sources of power bestowed upon us or created by us through social interactions. This tends to be called 'influence', rather than authority. Influence takes the form of persuasion, dialogue or debate. Frequently, charisma and personality style are informal sources of influence.

According to the literature there are five types of power; position, reward, coercive, expert and referent. The effectiveness of one type of power or another depends upon the situation, including the relationships among the people who are present. The following is a brief summary of some of the characteristics of power types.

Position power derives from the structure of an organisation: it specifies role relationships through the hierarchical ranking of positions in an organisation. For example, a nurse manager is said to have more power than a staff nurse. Other positional power derives from the level of

responsibility held, or from the social placement. Hence physicians are viewed as being more powerful than nurses. Position power is an important type of power and should not be underestimated. Nurses in positions of power frequently do not recognise or acknowledge that with their position power they could develop other kinds of power.

Reward power comes from the use of positive sanctions. Rewards do not come only in the form of increased salaries. Often we underestimate the strength of using reward power. Giving verbal approval, sending memoranda of thanks or an acknowledgment, recognising publicly the achievement of work done, are all forms of power through reward – and few of them cost money. To build better relationships among our constituencies, we would do well to support, compliment and acknowledge positively both our nurse and our non-nurse colleagues.

Coercive power involves negative sanctions, and although it has a place in management roles, the power base that is created through these sanctions is weak and short lived. One common mistake is the strict enforcement of rules. Rules are guides to action and should be interpreted according to the individual situation. A creative interpretation of a rule increases the dependency of the subordinate and thus increases the power of the manager.

Expert power comes from knowledge and experience. Nurses are knowledgeable and experienced in many areas – nursing as well as general areas of interests. Yet for some strange reason we sometimes devalue our knowledge base, or defer to another in conversation. Expert power is very influential. If nurses, as the largest number of health care providers, decided to utilise collectively their expert power for one single cause, there would be no greater exercise of power. Unlike position power, expert power resides with the individual. Contrary to those who believe one should keep knowledge to oneself, I believe that sharing knowledge increases personal credibility and enhances one's power.

Referent power is that power attributed to a leader by his subordinates because of the leader's personality characteristics or his measure of charisma. Followers want to emulate this kind of leader, who is said to have power because of the qualities referred to him by others.

It is especially important to also mention here the power of *persuasion* and the power of *delegation*. Power is obtained through influence and most frequently one influences another through persuasion. To be an effective persuader, one must be well informed and articulate. This means that one must do one's homework – consistently and thoroughly.

Power through delegation includes selecting the best possible people with whom to work. The manager then adds to his or her own power base

by delegating to the subordinate both the responsibility and the authority to act. Too often the nurse manager does not delegate important tasks, mistakenly thinking that he gives away power when and if he delegates. This could not be further from the truth. The more authority the manager gives away, the more he has, because the *reward* power of the manager enables him to evaluate the performance of the subordinate, which in turn, motivates the subordinate to assume increased responsibilities for her/his own performance.

McClelland has described the two faces of power as the 'personalised' face and the 'socialised' face. The former is defensive, seeking to win personally through personal domination. It is an attempt to compensate for weakness. The nurse manager who pounds the table with defensive arguments will never succeed. The socialised face of power, on the other hand, is characterised by strength and competence; it is interested in group goals. In an arena of socialised power, followers learn to become leaders. Nurse managers who use their position power, together with their expert and referent power, to achieve clearly articulated goals through persuasion, delegation and other means of influence, must plan ahead in order to present an offensive and not a defensive position.

Power is a measure of relationships among people. As we examine the issues of accountability and leadership for quality nursing care, we must be mindful of ways to maximise those relationships. The creative use of power offers one strategy for strengthening our position in the health care delivery system.*

The crisis in nursing remains grave. Anxiety is high among some nurse leaders. Frustration and 'burn-out' is evidenced among staff nurses. In addition, there are now many more professions attracting young men and women than in the past. We must be aware that potential nurse applicants may go elsewhere. If we are to attract candidates to nursing programmes, some notes of optimism and enthusiasm must be sounded. This is another of our responsibilities as nurse leaders.

Finally, may I remind you of John Kenneth Galbraith who said: 'All of the great leaders have had one characteristic in common: it was the willingness to confront unequivocally the major *anxiety* of their people in their time'.

*For an extended discussion of power see Chater's 'The Creative Uses of Power' in Conway and Andruskiw, *Administrative Theory and Practice*. Appleton-Century-Crofts, CUNN. 1983.

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2 Aaron H J and Schwartz W B. The painful prescription: rationing hospital care. Washington DC, Brookings Institution, 1984.
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DISCUSSION

Preliminary discussion following Dr Chater's paper centred mainly on comparisons in relation to power and leadership style: for example, in their use by doctors and nurses; the possible differences between male and female qualitative and quantitative skills and cultural differences.

It was generally agreed that it was always a personal responsibility to work at what one knew one was weak at, and if certain skills were lacking, nurse leaders should take advantage of the availability of the appropriate education. Some nurses present were able to give examples of where this had already been done and, as a consequence, increasing numbers of nurses were now responsible for their own budgets and staffing programmes. The ability to document outcome, however, was often a problem. A priority of politicians was to cut costs and nurses now had to learn not only to look at quality but also the cost of quality. They had yet to prove, for example, the advantages brought about by monies spent on the higher or advanced education of nurses. At the present time, even their basic training was under the microscope for it was considered by some that nursing could be undertaken by people after a much shorter preparation than is now customary in the majority of countries. Because nursing is an art and a science, it was an impossible activity to measure: it could only be evaluated in general terms. Medicine, although also a science and an art, still retained its mystery and consequently was rarely evaluated critically. There prevailed among the public a general assumption that 'if a doctor does it, it is good'. Perhaps nursing was too open in its aims and methods and needed to learn political strategies in order to be able to proact and attain the power it needed if it were to be self-determining in its education, management and measurement.

The group then addressed itself to two questions:

- Can the nurse manager be accountable for quality patient care with decreasing human and material resources; and within the context of changing value systems and cultural expectations?
- In what ways can nurse managers use the concept of power creativity to bring about change and/or improved relationships with others to influence quality care?

In discussing the first question, the group decided that the nurse manager could still be accountable for quality patient care providing certain conditions were met. For example:

- roles, standards and framework were defined
- the competence of nurse managers was ensured

- the extent of the nurse managers' authority was defined and agreed by, and with, others
- appropriate education was available to help the nurse manager to develop confidence and the ability to make judgements
- agreement within the nursing profession itself of levels of professional accountability
- agreement of care had been reached with the patients themselves

Participants believed that at the present time there was considerable difficulty in defining what nurses should be accountable for in the delivery of patient care: a framework for professional accountability was urgently required for resolving the problem of undertaking both medical prescription and specific nursing requirements. The legal position of the nurse required revision, for at the present time there was insufficient case law to help to define it.

A lack of confidence and a low morale among the profession were identified and it was thought that this could be due partly to an ad hoc response to current cost containment (that is, passive acceptance). Three possible responses to the present situation were suggested: a creative one, adapting to the new situation (yes); a competitive one, accepting the challenge to compete for scarce resources (maybe); or an actively negative one, refusing to accept the constraints (no). In all instances, nurse managers must be able to deploy resources effectively and efficiently whilst providing options related to measures and outcomes. The latter pointed to a need to provide relevant information (including anecdotal data) and research findings so that sound judgements could be made. It was emphasised that nurse managers are responsible for the climate and environment within which clinical nurses work but often there is a credibility gap between nurse managers and clinical nurses, a gap which must be bridged if both are to be accountable. Accountability needs to take cognisance of both content and context and it was in the context of cost containment that conflict between the two could arise.

Moving on to the second question, discussion first centred on the difficulty in establishing nurse power – whether it existed in all countries, and, where it did, the difficulty some nurses were experiencing in retaining it. Participants from some countries described how problems are especially compounded in the light of strong medical or political party dominance.

With Dr Chater's concepts in mind, the group decided to focus on nurse power according to category.

1 *Position power*, it was reported, exists in some countries but only in a very limited way in others.

2 *Expert power* It was recognised that nurses often lack confidence because of a lack of expertise. Therefore, before this concept of power could be fully exploited, post-basic and continued education for nurses must be actively and vigorously promoted in all countries.

3 *Coercive power/resources power* Participants believed that by their very numbers and their nearness to patients, nurses were presented with good opportunities to influence, but to date resources power had not been fully exploited.

4 *Reward power*, the group agreed, already existed for many nurse managers: they had the power to praise and encourage as well as to inhibit and discourage. It was in this area of power that potential leaders could be identified and developed.

5 *Charismatic power* It was believed at the present time that only a few nurses had this power, but when potential leaders were identified, seen and heard, it could be developed.

Several members of the group identified situations which they would like to change in order to improve patient care. They then described how they could use their present power to achieve the desired changes. The following are a few of the examples:

1 Desired change: *to structure service around patients' needs.*
Example of ways by which to achieve this:
- by nurses in top management positions discussing appropriate changes in policy
- by nurses using their expert power to demonstrate a more effective use of resources

2 Desired change: *to improve working relationships with other departments within a hospital.*
Example of ways by which to achieve this:
- by nurses arranging multi-disciplinary problem-solving sessions
- by setting up and negotiating interdisciplinary training
- by initiating role discussion

3 Desired change: *Education to enable nurses at an early stage in their career, to question and to contribute to issues relating to quality of care.*
Examples of ways by which to achieve this:
- by setting up improved training programmes
- by changing the attitudes of nurse leaders to encourage young nurses to be involved

4 Desired change: *Nurse managers to grasp the politics of health care.*
Examples of ways by which to achieve this:
- by encouraging nurses to move into political positions
- by using numbers/resources power

- by making full use of the media

5 Desired change: *to give patients first priority and to improve relationships with consumers.*

Example of a way by which to achieve this:

- by ensuring that the nurses' knowledge of consumer needs is conveyed to other disciplines

Other desired changes identified included:

- to improve the credibility of nurse leaders so as to ensure their respect
- to identify nurses with leadership potential and positively discriminate for their leadership development

Finally, participants identified an outstanding need for the creation of a supportive system among the leading nurses of different countries in order to exchange ideas on how to improve the nursing power base.

NURSING AND POLITICS

The second paper was given by Trevor Clay, General Secretary, Royal College of Nursing of the United Kingdom, who was introduced by Dr. Amelia Mangay-Maglacas, Senior Scientist for Nursing, Division of Health Manpower Development, WHO Headquarters, Geneva.

In preparing this paper, my thoughts have been dominated by the changes currently occurring in the nursing profession in the United Kingdom. As you may be aware, the recently completed review of National Health Service management under the chairmanship of Mr Roy Griffiths, has resulted in increasingly dramatic changes in the role of nurses within the management structure. For our colleagues from outside the United Kingdom, let me briefly recap.

Despite an extensive reorganisation of the National Health Service in 1982, a political decision was taken by the Secretary of State, following the Griffiths report, to implement a further restructuring. This was based on the premise that the delivery of health care through the National Health Service could be done more efficiently if general managers were appointed. These new managers (chief executives) could come from inside the health service, but the option to make an appointment from outside was provided. Of crucial importance to the nursing profession was that, ultimately, the responsibility for the nursing service might not rest with a nurse. The only exception would be when a nurse became a general manager.

Predictably, nurses have not done overwell in this competition. It gives no satisfaction to realise that they have done as badly as doctors. Indeed, the group that appears to have won out has been the administrators. For them it has been the culmination of a campaign which, after failure in 1974, has built strongly and consistently since. The consequences for nurses and nursing have yet to become fully apparent. It appears that some general managers see nurses as essential components of the management team at the most senior level. But there are many who do not. These are creating management teams which emphasise planning, manpower and finance – those services which have, as their first concern, process rather than structure. This was the College's greatest fear: that the debate about use and allocation of resources would occur in forums to which nurses did not have the right of access. True, any wise manager

would seek the advice of the appropriate professionals, but in many cases the demand for resources to meet a service need would now have to be made at one remove. It is difficult to know what effect this will have, but it does focus one's thinking as to why this has happened and what lessons are to be learnt from it. In considering politics in nursing, therefore, I want to use this 'case study' to illustrate both the failings and the achievements before going on to speculate about the possible ways forward.

Undoubtedly, the implementation of Griffiths was a political event, political with a big P. It was a decision taken by the Secretary of State, the most senior government minister associated with health care in the United Kingdom. It was a decision confirmed and upheld in Cabinet. (Some say that the Prime Minister herself was behind it.) Further, it was projected as being part fulfilment of an election manifesto pledge, and, most recently, at the Conservative Party Conference, was given as one of the reasons for increasing efficiency in the health service. The question to be posed, therefore, is how does nursing act politically, either at this level or more locally. Perhaps the question needs to be broadened to ask how do nurses act politically.

This question cannot be considered in isolation from the question of how nurses, as social animals, are affected by politics. To date, the emphasis has been on the political animal operating rather than the social animal being operated upon. This is not just a matter of semantics. It is a most crucial distinction, and, I think, a most enlightening one. The nurse, as an individual, has the option to engage in political activity – a term I shall return to later; it is a conscious decision. As an individual, however, the nurse cannot avoid being affected by both the process of politicising and by political decisions. Consequently, it would be far better to have a profession that was consciously aware of politics and had made an act of will to be involved politically, rather than being simply a cohort which is not even cannon fodder. Rather it is the very target area for cannon fire.

In her address to the Royal College of Nursing's Annual General Meeting in 1983, the President, Miss Sheila Quinn, invited members of the Rcn to become more active with the phrase 'Let's get political'. It was a statement which asked nurses to make the conscious effort to see themselves as political agents: to make the transition from being a group and individuals within a group which was acted upon by political decision-making processes, into an active political force. The call did not imply that nurses had never been political, it suggested that a conscious effort was required to establish nurses and nursing as a political force.

Ruth Schröck, in a paper in the *Journal of Advanced Nursing* in 1977 entitled 'On political consciousness in nurses', addresses this point in some detail.[1] She quotes an editorial of the *Nursing Times* (November 1975) which stated: 'Nurses on the whole are not political animals and, indeed, the profession has, by its attitude, ensured that this has been so'.

Her thesis is that nurses see themselves as complete social beings when they have established themselves in a family grouping and a specific occupational group. Her belief is that nurses know so little of the major social and economic factors which influence health care that they are unable to exert any influence on its process. The essential problem seems to be that becoming a nurse is an act of completion and self-actualisation of itself. If this is so, one must conclude that nursing provides sufficient rewards of itself to reduce, or even annihilate altogether, those critical faculties which would enable individuals to develop any political acumen.

The article highlights two very interesting phenomena in the politics of nursing. Firstly, there is the event which is sprung upon the profession, the surprise government decision, the unsignalled social change, the sudden historical event. Schröck suggests that the response of the profession to the introduction of the National Health Service in 1948, was an example of this. Maybe an extended historical perspective makes one wiser after the event than one could ever have been at the time. However, the creation of the National Health Service had its harbingers in the social legislation of the Edwardian era. The pace of legislation leading to health care for all had increased significantly during the decade preceding the First World War. It had its parallel in the changes in legislation relating to education. The Second World War hastened the rate of change and generated the political will to implement such major change. Sadly, the profession did not chart these changes well enough to be able to influence them. Gone were the days when Miss Nightingale could summon the Prime Minister to her bedside for 'A word in his ear'.

I would suggest to you that all subsequent reorganisations of the National Health Service in the United Kingdom have been greeted in the same manner. The Griffiths report is a classic example.[2] Few nurses paid any attention to the announcements in early 1982 that such an enquiry was underway. The attention of the profession was directed to the then current reorganisation. All the leading journals carried reports about the enquiry and updated the profession on Mr Griffiths' itinerary, the developments in his thinking and his general philosophy. Indeed, the national newspapers carried articles about it from time to time. However, the arrival of the Griffiths document came to many as unpredictably as a flash of lightning from a clear summer sky, its suddenness in the midst of

everything else that was going on having about it the feel of a stab in the back.

It is, maybe, the perceived suddenness which has made the profession slow to respond or it may be the second phenomenon to which Dr Schröck refers; that is, the slow pace of change in any political structure. So often pieces of social legislation seem to need to be piled on each other, almost brick by brick, in order to achieve major change. Many commentators have noted the volume of social legislation enacted in the UK since 1945. It is a massive programme of activity, effected through governments of different political hues which has not only changed the way individuals are free to operate in our society but which has set new and important parameters for the delivery of health care in the UK. Nurses still lack the ability to review this in order to determine its significance for health care. Sadly, it is difficult to find much documentary evidence that nurses have changed any of that legislation in order to deliver better health care, or even had a significant voice in the pursuit of any of that legislation.

A point implicit in Schröck's paper and which needs to be made quite explicit when considering politics in nursing is that at the time of social legislation, because it has implications for health care, one must also think of nursing legislation. If anything has to do with health care it has, by direct association, something to do with nursing. Failure to perceive this has resulted in nurses being seen to be the political pawns referred to earlier. It is tempting to accept the *Nursing Times* editorial view of 1975 and blame the profession for making nurses what they are. However, this is not a satisfactory conclusion without further analysis. Bevis in her text on *Curriculum building in nursing – a process* offers a very challenging hypothesis as to why nurses and nursing have not been politically active but have become more so in recent years.[3] She presents a review of the competing nursing philosophies which can be identified as underlying nursing practice since 1850 or thereabouts. Her description of a philosophy as providing a point of view, belief construct, a speculation about the nature and value of things, lays great emphasis on those two great intangibles, beliefs and values. She suggests that in nursing our value systems and beliefs contain many elements, but four main ones. They arose at different points in the history of nursing and have produced different decision-making processes and indeed different types of decisions. Each philosophy has had a period of dominance before. However, none has been completely lost and so all remain in operation even if only as 'trace-elements'. This suggests, even before going on to look at the inherent difficulties of a multiple philosophical system, that

conflicts exist in nurses and nursing.

Essentially the time-scale runs like this. Before 1880, nursing was most strongly influenced by asceticism. This laid great emphasis on the patient/client as a spiritual being, it centred on the self-denial of the nurse, emphasised in nurses the need for self-discipline and provided a sense of vocation akin to the religious life. Nurses did not assert themselves, devoted themselves to duty and sought spiritual growth through hard work.

The next major value system to exert influence in nursing was romanticism. This began to be present in nursing thinking from the late 19th century through to the middle of the 20th. Importantly, it is non-empirical. It lays emphasis on emotions, experiences and idealism. It replaced the self-denial and spiritual growth of asceticism with loyalty to the doctor, to the hospital, to the ideals of the school of nursing, and to the patients. It produced in nurses a dependence on doctors and supported the belief that females are subservient. The nurse as a handmaid originates from this belief system. Some elements of this persist in the literature about the concept of a Super-Nurse/Junior Doctor.

The Second World War produced a massive bout of reality orientation in nurses. It was manifested by a transition to pragmatism. Such a philosophy holds that value is based in practical use and consequence. It permitted the development of ancillary services which 'picked-up' bits of the nursing role that could not be fulfilled at that time by nurses. It emphasised the practice elements of nursing and confirmed nurses as individuals who responded to doctors' needs rather than to clients' needs. Patients became 'the appendix in bed 6', rather than Mrs Jones. Further, it encouraged health services to specialise and also prompted nurses to investigate their practice.

From the late 1950s onwards, a move to humanism is detectable. The influence of Abdellah and Maslow is well established. It produced in nurses a concern about the whole person, family, community. The human being becomes central to nursing, not his spiritual welfare, and not the nurses' devotion to god, country, doctor, disease or diagnosis. The most recent and aligned development is the adoption of humanistic existentialism. It introduces some very important values. For example, that no matter how much scientific data is produced to explain the functioning and nature of a human being, that person is still greater as a whole than the sum of the parts. Further, it asserts that human beings are free to choose and free to reject, no matter how good the health service or the health care professionals' advice. It lays the emphasis on caring and

makes nurses first and foremost accountable to the patient/client.

It is obvious, therefore, that nursing, in its recent history, has adopted a number of value systems as its principal philosophy. This brief review also suggests reasons why nurses are, comparatively speaking, apolitical. Humanistic existentialism is only traceable in nursing literature in any substantive form from the mid 1970s. Indeed, in the United Kingdom, one can almost tie it down to a date in 1977 when the revised syllabus of general nurse training was issued by the then General Nursing Council. It contained for the first time a process of nursing care which made no reference to the spiritual needs of the patient. Further, it referred to the delivery of care in humanistic terms. The conflicts posed are quite immense, because the philosophies pull nurses in diametrically opposed directions. In the last 100 years, nurses have had to move from a position of complete subservience to one of total accountability in many areas, an accountability enforceable with the full rigour of the law. The perception of the patient/client has led to change from seeing the individual as gaining spiritually from the sufferings endured, and totally dependent on the doctor and nurses, through to a person who can exercise the sort of choice which rejects advice on smoking or diet or birth control, but still expects to be cared for when entering hospital for a termination of pregnancy or treatment for heart disease.

Not least, the profession has had to rid itself of the handmaiden role and move into a situation of potential and sometimes open conflict with the doctor, as the nurse has taken on the role of the patient advocate. Probably the most contentious change has been the aspiration to develop an independent knowledge base for practice which conflicts with the medical knowledge base. The conflict arises because of the eclectic nature of nursing studies and the humanistic emphasis, which is opposed to the paternalistic model so often pursued by our medical colleagues. Nurses no longer need to speak from an emotive base, rather there is an empirical base for their assertions and, increasingly, they are assertions which make the medical profession and other health care professions believe that nurses are increasingly speaking effectively and forcefully on behalf of the patient. To put it bluntly, despite the conflicts arising from our history, nurses are becoming more political and are stealing marches on the other health care professions.

I want to suggest that the nursing profession in the UK is fulfilling the first of the two major political moves open to the profession as suggested by Ruth Schröck:

1 Either one succeeds in demonstrating that this group fulfills the existing criteria to a much greater degree than the resource

allocating agency apparently assumes, and therefore deserves higher priority, or

2 One must attempt to change the criteria by which priority is given in allocating resources.

Nursing has been slow to follow the first tactic. The influences of asceticism and romanticism have ensured that in public the profession remained deferential and acquiescent. The other important observation is that it was only when the influence of those two value systems began to wane that those who did blow the profession's trumpet were no longer seen as deviants and troublemakers.

The second tactic is not a simple matter, especially when the slowness of change is remembered. However, a not insignificant change of this nature was the recent establishment of a pay review body for nurses. The profession had long seen the former negotiating mechanism as working within inappropriate parameters. The negotiations successfully changed the criteria by which the decisions about pay were to be made. It also allows me to add a rider to this second tactic which is – 'we must keep the criteria flexible'. The temptation is always to agree sharp definition. This limits movement. In fact, it is movement that is required if unnecessary confrontation is to be avoided. Such flexibility permits extended negotiation and the option of revising the content of agreed criteria.

To summarise this part of the paper, therefore, I would say that currently, in the United Kingdom, the profession is demonstrating increasing political awareness, is resolving the conflicts of its value systems and becoming aware of its political power. In the next section I am going to look a little at leadership and its importance to the profession.

Since the time of Florence Nightingale and Mrs Bedford-Fenwick, nursing has been gifted with occasional leaders of great charisma and drive. Unfortunately, as a whole the profession has not generated this calibre of leader consistently. Leaders in the profession have, too often, portrayed themselves as reactors to events and preservers of the *status quo*. While these are important functions, to my mind they smack of the administrator rather than of the leader. It reminds me of the parable of the talents. The man who simply preserved what he had, had it taken away from him. In fact it was given to the one who had done most to change and develop what he had received. Now while I would not normally describe the Gospels as a manual on political strategy, the man with only one talent is a paradigm of nursing leadership in many respects. Fear of his master stopped him from experimenting, developing, initiating, even controlling his own destiny. This reminds me so often of nursing – it is almost as if, as a profession, we are so fearful of losing what we have, that

because of our failure to develop, change and initiate, we do in fact lose.

To my mind, the most important element of leadership is the ability to implement change. It is that which distinguishes administrators from managers. Managers have the ability to make decisions. The process by which these decisions are made varies greatly. The *Wall Street Journal* recently devoted a substantial article to this very subject. Reviewing five of America's top business men, it explored the methods they used and discussed in detail the nature of their personalities. It was not that any of them had ignored any established theories of leadership, rather that they had adapted them to fit within their natures and working methods.

Zaleznik suggests that a further distinction between manager and leader is justified. He argues that leaders, 'are obsessed by their ideas, which appear visionary and consequently excite, stimulate and drive other people to work hard and create reality out of phantasy'.[4]

In contrast, the manager is hard-working, analytical, tolerant and fair-minded, demonstrates a strong sense of belonging to the organisation and takes great pride in perpetuating the *status quo*. This has great similarity to the administrator which I described earlier. I would like to be able to equate manager with leader. This is because my concept of an administrator and Zaleznik's idea of a manager both focus on process, the methods required for achieving the agreed ends. In contrast, leaders are concerned with substance and function, the matters which would form those ends. Sadly, nursing seems to have produced reasonably good administrators but not many leaders.

As I stated earlier, the significance of leaders is in their role as change agents. One weakness in the current debate on nursing leadership is the lack of knowledge about the nature of nursing leadership. Merton in an article in the *American Journal of Nursing* said:

> That leadership is of various kinds, that it works its ways variously under various conditions, that it has its distinctive requirements and its processes, that it has too its pathologies – all means that leadership is not simply a mystique. Slowly our understanding of leadership grows and sometime; perhaps, it will emerge from the sociological twilight into the full light of day.[5]

Lancaster and Gray use this as the introductory heading to their chapter in *The Nurse as a Change Agent*.[6] It reviews much of the pertinent literature in the field before attempting to justify the assertion that 'Leadership is needed in every nursing activity'. Interestingly, their thinking takes them back to the work of Bennis who argued that new forms must develop to meet the changes that occur in organisations.[7] He

argues that there is a relationship in terms of speed between rate of change and development of leadership. Further he notes that:

> Leadership of modern organisations also depends on new forms of knowledge and skills not necessarily related to the primary task of the organisation. In short, the pivotal function in the leader's role has changed from a sole concern with the substantive to an emphasis on the interpersonal.

This is interesting because despite the time lapse between Zaleznik, 1984, and Bennis, 1968, it is suggested that leaders should not just concern themselves with the matters of substance which require decisions and therefore change, but with the interpersonal nature of leadership. Bennis describes four other skills which leaders must possess:

1 Knowledge of large, complex human systems.
2 Practical theories for guiding these systems, including the development and nurturing of participants.
3 Interpersonal competence, especially in regard to recognising the effect one has on others.
4 A set of values and competencies that enables one to know the best way to approach others.

This is a most daunting list and may account for why there are so few 'good' leaders anywhere, let alone in nursing. It lays emphasis on the interactive elements of leadership. A leader displaying such skills would not exist in an ivory tower but would be attempting to use his/her skills in such a manner as to effect quite radical and fundamental change. The change would be initiated through self and then through others, rather than by an imposition from above.

Many will feel uncomfortable with this, because it establishes two important points. Firstly, that leaders must make use of their own personalities and secondly that leadership is a tool to be used to effect change in others. Lancaster and Grey suggest that to adopt such an interactional approach, leaders must have the following characteristics:

1 Confidence in one's own ability.
2 Respect and trust in others.
3 The ability to communicate clearly and listen effectively.
4 The ability to make decisions.
5 Planning and organising skills including delegation, providing adequate directions, guiding and coordinating.
6 Lack of overwhelming anxiety; the ability to maintain control in many different situations.

7 Good knowledge of the field in which one is a leader.
8 Considerable energy and ability to stick to the task at hand.
9 Patience and consideration for the needs of others.

This you will have perceived is essentially a humanistic approach. It lays emphasis on, and gives value to, the human being. It, therefore, is congruent with the principal philosophy dominant in nursing at the moment. It is tempting to propose that it is the model which current and aspiring leaders of the profession should adopt. Further, it provides a structured approach to leadership and therefore in some respects demystifies it. It emphasises the skills element, implying that these are all skills which can be attained. In fact, it offers a base on which the interested manager/leader could experiment by giving more weight to one characteristic rather than another in order to affect types and rate of change.

To summarise this section, therefore, I would suggest to you that leadership in nursing is a function of personality and that it is one which can be learnt and developed. Its importance is that, without leadership, the profession lacks the power and motivation to be political and to become a major political force. In the final section, I want to go on to look at how the profession might be led into being more political both in macrocosm and microcosm. I will also be laying some emphasis on the role of education in this.

In her paper earlier this year in London to the Advanced Nursing Practice Conference on 'Accountability in nursing practice', Margretta Styles identified one particular area of accountability in which nurses could include being 'an astute political activist'. Interestingly, her emphasis was on what might be described as politics with a capital P. She described the constraints applied by Government and the need for the nurse to resolve the potential conflict between the demands of government in terms of resource restraints and so on and the needs of patients. She sees resolution of this by 'The most vigorous and skilled pursuit of public policy changes'. In other words, nurses both as individuals and as professional groups must get intimately involved with the political processes of central government if they are to exercise their accountability fully.

In contrast, Sara Archer, whilst acknowledging the importance of big P politics lays much more emphasis on the small P politics of health care at local level.[8] She starts with the belief that nursing curricula are already overcrowded. Annie Altschul was also concerned about this problem. In 1982, when considering the place of hygiene in a plan of training, she wrote:

> If I had the opportunity now to plan the nursing curricula from scratch, it would not be hygiene which I would include, but politics, sociology and anthropology. Knowledge of hygiene would develop as a natural consequence of an interest in those subjects which, to me, seem an essential basis for nursing.[9]

This statement is interesting to me for two reasons. Firstly, that the three sciences replace an element of the practice process and, secondly, that politics comes first.

Archer expands on the role and teaching of politics, describing the need to be involved at all levels in political processes. In order to do this, certain skills are required, skills that can be included in basic nursing curricula and which can be honed and perfected at a local level before going into practise them in longer and perhaps more daunting circumstances. They are:

1 Writing skills.
2 Speaking skills.
3 Interpersonal skills.
4 Committee conduct skills.
5 Administrative skills.
6 Research skills.
7 Skills of comprehension.

While these are undoubtedly the principal abilities required to take part in any political activity, they are also skills which we should be able to expect any competent nurse to display. The real problem may be that nurses and nurse education have not actively considered bringing together these functions in this manner. Not surprisingly, when packaged in this format, the functions are seen to be logical and natural. Unfortunately, nurses have not demonstrated that they can take the skills they have acquired to meet one remit and apply them to another. If we are to continue to prepare nurses for training, it would be very appropriate to attempt to give them the ability to generalise these skills and reorganise them in order to achieve the change which they may wish to obtain.

The role and function of nursing associations in this process should not be ignored. Not only does an effective nursing association operate on behalf of its members in big P politics, it also functions at a local level. One of its most important functions is the involvement of members in activities which permit them to develop and refine political skills. They may use them within the organisation to pursue sectional interests or promote structural change. Increasingly, they can use such skills at a local

level in the pursuit of changes in the delivery of health care (in the UK), by the lobbying of district health authority members, local councillors and local members of Parliament. The members of the Royal College not only have the opportunity for this sort of 'on the job' experience, but can actually attend short courses of various forms to meet these needs.

In a macro-sense, the role of nursing associations is an expanding one. The need for nurses to be heard at the highest levels of government has necessitated a more outgoing approach by nurse associations. In the United Kingdom, this has been typified by the increased contact between government and the profession's organisations. This is not limited to formal negotiating mechanisms or highly publicised meetings with Ministers of State, but includes more informal and frequent checking of stances on particular issues and the inclusion of Ministers in the informal, social gatherings of conferences and so on. This increased involvement in the political arena has been matched by the most phenomenal increase in membership of the association in the UK and a marked increase in the number of nurses who are active within it. The membership of the Royal College of Nursing, for example, has increased from nearly 80,000 in 1977 to very nearly a quarter of a million nurses in 1984. This means that between 60 and 65 per cent of those nurses eligible to join have, in fact, joined.

The next step forward is to enable and encourage nurses to be more political. To this end, the College has recently appointed a political and parliamentary coordinator. The intention behind this development is to further and to exploit the current work, to lead the members of the College into a situation where they deliberately obtain the skills identified and learn to apply them. The unique regional structure of the Rcn will make this possible.

In conclusion, there is a further point I would like to put to you. Arising from the conflicting values that nurses have, there is a basic discomfort with power systems, especially those power systems which are overtly political. This manifests itself in many ways, not least in the way in which nurses pull back from situations when they sense that they might begin to effect real influence and change. Whether this is a demonstration of inferiority produced by this conflict of value systems or simply lack of knowledge of how to use the success of effective change for the good of patients and the profession, I am not sure. But, undoubtedly, it weakens any case made for proposed change through political processes if there is a belief, based on experience by one's antagonists, that there is a better than evens chance that if it looks as if the nurse is on the point of achieving his/her objective, he/she will withdraw.

This difficulty is made no easier to resolve when the current sectional interests in nursing are considered. In the United Kingdom such divisions are frequently highlighted by the competing political interests of the statutory and professional nursing bodies. This is manifested on a world-wide scale in the nursing profession. The preferred solution is to seek to grow in influence politically (both big P and small) and for leaders to accept that they must be brave enough and sufficiently far seeing to sometimes follow the crowd but, more often, to be out in front, pointing the way ahead. In so doing, they must set new frontiers and evolve new approaches to effect change. A current example is the resistance to university based education for nurses which is being expressed in many parts of Europe. The need had been long established; research supports such a move but the profession has been slow and fearful in accepting it. Leaders are required in order to push the change through and to take the profession with them.

The role of nursing associations is clearly crucial in achieving political change for nursing. With stronger political claims from the profession and stronger governments, the role of the nursing associations is more important than ever before. However, the lack of unity and the fear of power is surfacing once again in the UK as the Rcn approaches 65 per cent of its potential membership. Nurses from smaller organisations are not enjoying such benefits and are increasingly taking out dual membership. The biggest problem, therefore, is the enemy within. The need is there for leadership in the profession and in the nursing associations. If, as Rab Butler said 'politics is the art of the possible', it is up to the leaders in nursing to determine what is possible for the profession and to be sufficiently politically active and aware to achieve it.

I believe politics is both exciting and enabling. Like power it has had a bad press and is seen as more negative than positive. More than that, I believe it is vital that the profession now grasps the political nettle as a matter of urgency. With the political and economic climate which exists in many parts of the world, it is imperative for its very survival that leaders of nursing become involved with this sphere of society. It could, used sensitively and positively, be the profession's lifeline.

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DISCUSSION

The reactions of British nurses to the Griffiths report were seen by the seminar's participants as good examples of the possible responses (yes : no : maybe) to cost-containment actions by politicians, discussed the previous day.

At first, the Royal College of Nursing had reacted to Griffiths' proposals by a loud 'no'. This had had little, if any, effect on the political decision-makers. Some nurses on the other hand (saying 'maybe'), had seen applying for posts as general managers as a 'challenge' and had 'competed' for the limited number of these posts. Now it was considered that the most sensible answer was 'yes' and the College was encouraging nurses to adapt creatively to the new structure. It was thought that by limiting their area of responsibility it could provide an opportunity for nurse managers to get to grips with purely nursing matters, and to close the widening gap between nurse clinicians and nurse managers. The main concern was to ensure that every health authority appointed a chief nursing officer for it was vital that a nursing voice was heard in each. It was suggested that this new reorganisation of the National Health Service management structure in the United Kingdom could also have the effect of uniting doctors and nurses, healing the rift which had developed between them in recent years. It was reported that in Norway, this division of the two major health professions had been recognised as a major problem and deterrent to good team work. Consequently, two representatives of each professional association (medical and nursing) had been appointed by the Ministry of Health to discuss it and to suggest ways by which it could be resolved.

Members of the group agreed that one characteristic of the majority of nurses everywhere was to react to a crisis rather than to anticipate it. It was believed that this was due partly to a lack of unity within the profession itself; in recent years a plethora of sectional interests had developed throughout the world. Often nurses who worked under the heading of medical specialities felt, and showed, more allegiance to their speciality than to their profession. This meant that when one group did foresee a crisis, others either ignored the warning, were apathetic, disinterested or failed to plan the necessary political strategies and mechanisms for dealing with it in the overall professional interest.

In discussing how to increase the effectiveness of nurses and the profession in influencing, and making, health care policy at all levels, the group decided that the first step was to develop a political power base

from which to exercise all five power concepts identified the previous day.

This, they believed, could be achieved by the following actions:

- educating all nurses into an acute awareness of political issues and the contributions they should be making in relation to them;
- developing links with Members of Parliament (MPs), government departments and Ministers;
- watching the actions and responses of other groups (for example, doctors) and, when appropriate, set up coalitions with them (it was emphasised that nurses must be prepared for the 'give and take' this would inevitably mean);
- taking part in political campaigns to ensure that manifestos contain health statements which are in line with nursing policy;
- developing effective and efficient communication systems to keep members of the nursing profession fully informed and to ensure unification of nursing views;
- producing evidence through studies/data collection/options (including the use of outside experts as and when necessary to ensure a positive contribution);
- setting up lobbyists;
- making full use of the media.

Another mechanism identified by the group was to ensure that nurses sat on policy-making committees. This would entail comprehensive briefing of, and supportive systems for, such nurses. It would also be necessary to develop an awareness of, and an involvement of nurses in commenting on consultative documents, so that their views and opinions could be given to the committee membership.

It was also suggested that relevant briefings and support systems should be extended internationally, so that global 'early warnings' could be given when necessary. This could mean improving existing nursing networks or, possibly, setting up new ones. The involvement of outside nursing consultants; (for example from the World Health Organization and the International Council of Nurses) would be essential to their success.

Another mechanism agreed by participants, related to nurses working in government departments: their role should be established or reinforced as appropriate. This could be done by:

- setting up formal and informal communication systems;
- ensuring all members of the nursing profession were aware of the role of government nurses;
- agreeing nursing strategies between the nursing profession and government nurses;

- outposting nurses into government departments, for example, for research projects or for educational experience.

Turning their attention to the political actions they planned to take on their return home, the group had many ideas which included the following:

1 Set up communication networks with others in order to:
   - gain a unified nursing view; and
   - form coalitions with other professional and/or consumer groups.
2 Stimulate and arouse the nursing profession within each country. Strengthen the national nursing association and encourage strong links with the International Council of Nurses. Also use the latter to arrange international lobbying activities.
3 Develop a political power base by:
   - informing/educating nurses of the need and educating them accordingly; and
   - forging links with MPs and Ministers.
4 Identify the leaders in nursing who will activate others to educate and involve their colleagues in politics.
5 Make better known the role(s) of the government nurse(s).
6 Establish or improve formal and informal nursing communication between international organisations (ICN and WHO), and nursing leaders in each country.

Encouragement was forthcoming from nurses who were able to report examples of the successful outcomes of positive manipulation. (At this point, it was suggested that 'manipulation' (like 'power'), was a dirty word to nurses, but as it was an activity nurses practised daily they should practise it positively and in the interests of their own profession.)

Example 1 (Proactive coalition of nurses) In California, due to strong medical leadership, the mutilating operation of mastectomy was the prescribed treatment for all breast cancer. The nurses of the state had joined together to inform women about other treatments which could be effective (for example, radiotherapy and cytotoxic drug therapy). This information had been imparted in some secrecy but now, with a unified protest against inevitable mastectomy, women with breast cancer were given all options.

Example 2 (Proactive coalition with patients) In the Cameroons, many mothers were having trouble in weaning their children. Young, intelligent mothers were identified and suitably advised by nurses. They, in turn, became role models, passing on the advice they had received. According to the setting, this ripple-effect mechanism could be used in relation to a variety of health related problems and issues.

Example 3 (Proactive professional 'hiring') The Canadian Nurses' Association (CNA), recognising the need of nurses – both individually and collectively – for ego-building, had hired a firm of publicity agents to 'sell' the objectives of the CNA. This had resulted in better understanding and respect between the general public and professional nurses, each recognising the value of the other's time, expectations and goals. Party politics had been left aside.

Example 4 (Proactive parliamentary/political lobbying) In Norway, it had been realised by the medical and nursing professions that politicians were making health-related decisions because they were ignorant of their complexities. The Norwegian Nurses Association had assigned individual nurses to certain politicians in order to influence them. In fact, they had fed the politicians with so much information, options and issues, that the latter had been paralysed and had informed the Minister of Health that they were no longer prepared to make decisions in such a specialised field. Consequently, nurses as well as doctors, were now being used as advisers on health matters to the Norwegian Government.

Example 5 (Reactive influence) In Holland, because of budget cuts, a crisis in the health service was reached and nurse leaders, without being asked, offered advice to their government. This had proved to be so valuable that appropriate channels were established and the advisory mechanism is now permanent.

It was recognised that if nurse leaders were to be astute political activists and if their statements were to be convincing and of conviction, education for political effectiveness was a top priority. Not only must nurse leaders have political values and attitudes (the positive aspects of dedication, idealism, technical competence and respect for freedom and care of the whole person), but they must also have political knowledge and skills. It was suggested that the latter fell under six main headings:

1 Social context of health care: (for example, epidemiology, demography and social changes which affect the demand for nursing).
2 Organisational context of nursing.
3 Interpersonal skills (for example, communication and committee skills).
4 Critical skills (for example, making constructive critiques of consultative documents and research reports).
5 Manipulative techniques (in the positive sense).
6 The ability to play 'bridge' or 'poker' (the 'game theory') and not show all 'cards' until one is sure of winning the point – and the game!

Finally, a plea was made by the chairman for nurses to be involved, not only in nursing matters, but in all aspects of human welfare and its

management. Even though 'health for all' might sound unrealistic, it could be used for organising collective strategies and as a rallying and unifying call against such health destroyers as pollution, cigarette smoking, noise and nuclear radiation.

But if nurses accepted these additional responsibilities associated with policy making and decision taking on general health issues, they were into the bigger game of health service management. And how many had the necessary competence, knowledge and skills such as the Griffiths report called for in the general managers it prescribed?

CONFLICTS ARISING FROM BEING A HEALTH PROFESSIONAL IN A MANAGEMENT ROLE

The third paper was presented by Mrs Martha Quivey, Director of Nursing Services, Oslo, Norway, who was introduced to the group by Mrs Rosemarie Weinrich, Executive Director, Professional Nursing Association, Frankfurt, Germany.

Let me clarify immediately that in this context by a health professional, I mean a professional nurse.

When I was in the United States of America last summer, I happened to be in Minneapolis/St Paul, just as a rather lengthy nursing strike was drawing to an end. A television station presented a one-hour long discussion between the local nursing organisation and the administrators of a hospital, including its director of nursing. (The strike was related to working conditions and not pay.) That programme was a prime example of the conflict that can arise from being a professional nurse in a management position when the professional organisation and the hospital management hold completely different views. I must admit I felt extremely sorry for the director of nursing who, although not a member of the nursing organisation, obviously identified with many of its views, yet had to defend those of her employing authority.

In going through relevant literature, I find that there is much more written about possible conflict between the nurse manager and non-nursing members of a management team, than on the possible conflict between a nurse manager and the nursing staff. Could this be because there is no conflict? If this is the case, we should not spend much time on the subject! But my own experience is that there are conflicts of this kind; one may find them when representing one's professional organisation in a situation involving a hospital administration or when one teaches in a post-graduate programme of nursing administration – in the latter instance, strong criticism of nurse managers is sometimes made by the students who are also practising nurses. Previous speakers have already touched on this subject by suggesting that nurse management is often far removed from the practitioners of clinical nursing. I think that this is partly due to three kinds of conflict.

First, there is the conflict within the nursing manager herself, which is often caused by her awareness of the need for improved nursing care versus her recognition of the limited health care resources.

Second, there is the conflict between the manager and her/his staff. While this also may be caused by tight economical measures, often it is due to the organisational structure.

Then there is the conflict between the nurse manager and non-nursing colleagues. This is often caused by a lack of good hard data to support the nursing point of view. Another fact which is mentioned only in more recent writings, is that often the nurse manager is the only woman in the management team. This gives rise to problems well known to most of us. In addition, the nurse manager sometimes is the only health professional in the management team.

It may be helpful at this point to define what I mean by 'professional' and by 'management'. There are several definitions of 'professional'. Most of them describe what is required to be called a professional. These usually include:

1 A body of knowledge and specific skills obtained through education.
2 Service orientation rather than merely financial orientation.
3 A code of ethics, self-discipline and a system of peer review.
4 Individual autonomy with legal sanctions for the work of the practitioner.
5 A monopoly for carrying out certain functions which is recognised by society.
6 A professionally based culture.

Nursing, in varying degrees, depending upon each individual country, fulfils these criteria. I believe nursing will be recognised as a profession in an increasing number of countries.

As for a definition of 'management' – there are certainly enough to choose from. A rather simple one, used by WHO in their publication, *On being in charge*, is 'Management is saying what one wants to be done, and then getting it done'.[1] This is closely related to the management by objectives model. It may sound somewhat authoritarian, but it carries an important point – it spells out what one is trying to achieve. This, in itself, requires clarification of values, goal setting and information. The authors of the book *In search of excellence*,[2] stress that businesses which are successful are those which have few goals, clearly defined goals and a constant information system to make sure everyone knows the goals. So much for definitions.

Now – to the three kinds of conflict.

1 *Conflict within the nursing manager herself* Are there different value systems for the professional clinical nurse and the nurse manager? One hopes that the goals of the health agency in which they are working will be the same for both, but that does not help much if the goals are very

general and if none has been given priority. It is my experience that this is usually the case. In terms of priority, setting such goals provides little help, because they imply that everybody will get everything. This, of course, is not true. Surely the nurse manager will see nursing as the top priority, but it is impossible not to accept that the representatives of other groups also have a legitimate cause to see their disciplines as priorities. One has to see nursing, therefore, as just one part of the total health care setting. This may well mean that as a manager one must compromise on issues which one would not wish to compromise on as a nurse. This certainly gives rise to conflicts within oneself.

What expectations do we have of ourselves? Are they that we will always win? If so, frequently we will lose face as well as the case. How much influence does our early nursing education have on us when we become managers? We are taught that the patient must always get well, that is, we must always win. Do we think of management like that? It is important in management to have expectations which are realistic and it is equally important to let one's co-workers know what these expectations are. Frequently, nursing staff expect their nurse manager to achieve everything that each unit requests, whilst at the same time, her colleagues in the management team expect her to recognise the need to compromise and to give priority to what is best for the total system. Such different expectations of one's behaviour and achievements must give rise to conflicts. So the need to define one's own expectations and to communicate them to all members of staff becomes crucial. It is my experience that, unfortunately, students in nursing management programmes frequently have little understanding of the problems facing a health management team. Bargaining processes, for instance, are not well understood.

2 *Conflict with staff* Another area of conflict may lie in the organisational structure. Most health care settings have long histories of bureaucracy. Although today everyone is talking about decentralisation, this does not come about quickly, while responsibility and accountability are often not decentralised clearly. As nursing becomes increasingly profession oriented, we will face a dilemma of loyalty – professional versus the bureaucratic model. Many nurses are already experiencing it.

The differences between the two models as listed by Blegen and Nylen in *Organisational Theory* are on page 40.[3]

If they are right, then the bureaucratic-oriented manager will expect loyalty to be to the organisation and that decisions and actions will be based upon the goals of that organisation. Such managers will operate an authority which is vested in their positions within the organisation and

	Models	
	Bureaucratic	*Professional*
Loyalty to	The organisation	The profession
Decisions are made on basis of	The goals of the organisation	The goals of the organisation and professional standards
Authority is based on	Position	Professional competency
Careers are sought in	The organisation	The profession
Responsibility is felt to	The organisation	The organisation and professional ethics
Status is based on	Position	Professional competency

they will have a career ladder based on the bureaucratic organisational structure. In turn, they will expect from staff a responsibility to the organisation and that each person's status will be vested in that person's position in the organisation.

A professional's first loyalty is to the profession and although she may base decisions and actions on the goals of the organisation, she will also base them on professional standards. It is to be hoped that these goals and standards coincide, but when they do not, some problems result. Professional authority is based on professional competency, which may or may not be present in the person in a position of authority. If the professional essentially sees a career ladder within the profession, we may find some strange developments, both in career ladders and in the authority vested in positions within the organisational structure.

While the professional feels responsible to the organisation, she also feels responsible for professional ethics. Again one can only hope that there will be no difference between the two.

Finally, the professional sees her status based on professional competency but this may not be the same status system as one based on position. While as yet we may not see this type of conflict very much, we do see it in medicine, and, with increasing professionalisation, it may become a real problem in nursing. Much depends on whether we

maintain a bureaucratic organisational structure and whether the professionalisation process of nursing continues.

It is important to realise that this is a structural conflict and not a personal one. As yet the system creates problems because it has not been adjusted to accommodate recent developments.

Another conflict may arise if nurse managers have different theoretical bases for clinical nursing and nursing management. For example, when a nurse manager pushes a theory which favours practising self-care and self-help or building on the patient's own resources, but does not favour self-reliance and independence in and among her own staff. The staff will be confused. Many authors, (including Barbara Stevens[4]), have pointed out that there must be coherence between the nursing theory one favours for the nursing department, its organisational structure and the administrative theory, and action that actually takes place in that department.

Another important factor that may give rise to conflict is concerned with the fact that staff very often do not understand that once a political or top administrative decision is made, all members of the management team must remain loyal to it. Before a decision is reached, nurse managers may try to influence the decision-making process, sometimes to no end. Their staff may well view them as unreliable when they subsequently carry out decisions they have not wanted and have fought against.

Staff members may continue their fight legitimately, but it must be through their organisation, not through the nurse manager. The authors of *In search of excellence* maintain that the interests of an organisation and the interests of its staff are inseparable, and that if the interests of the latter are not met, the organisation will fail. They may be right, but I am not sure. I am sure, however, that a nurse manager must be loyal to decisions which are made politically or in top administration. Also that it is important that her staff accept this, but that at the same time they know where to go if they want to pursue the lost issue.

Managers are frequently accused of not giving enough information to staff. In a management seminar at a university hospital in the USA this was frequently brought up by middle management representatives as a problem.

The hospital administrator finally got so annoyed that on return he practically buried the hospital units in paper. It did not solve the problem and the complaint changed to that too much information was being given. His action, however, gave rise to a useful discussion on what is *relevant* information.

We also tend to forget that while we, in the management team, receive a good deal of information, it does not go to everyone. I remember sending out a short memorandum about a complex issue. No one understood it because the issue had had a long history, and without that my memorandum made no sense at all. So information must not only be relevant but also contain enough background to make sense.

3 *Conflict within the management team* Nursing is not easy to 'sell' to non-health managers (or it may be we are not good salesmen!). It is often very hard to get results without presenting good, solid data. In the past, nursing has had rather few of those – and I am not convinced that we should have. At least I do not want to get back to that era when in order to be heard we tried to transfer all soft data into hard data. It gave some strange results. But a management team consisting mostly of male economists and lawyers has trouble in understanding anything that is not in numbers, and often we feel we do not get heard by them. Sometimes it is our own fault. For example, nurses frequently have insisted that a larger number of staff will result in better quality nursing care. To some extent this is true, but it took us a long time to realise that we needed to look also at the composition and qualifications of those staffing figures. It took even longer to begin to define 'quality care': to explain it to ourselves let alone to non-nurses. With that background, perhaps it is easy to understand why 'selling' nursing to economists has been hard. This is particularly true when the nurse manager is the only health professional in the team. My experience is that it is easier to obtain the agreements one seeks when other health professionals are present. On these occasions it is easier to get acceptance for soft data and above all it is easier to get acceptance of the fact that short term economic gain *may* result in long term poor health.

It may also be difficult for our non-health care colleagues to understand us when we point out that health needs are constantly changing – and that, in turn, these changes must lead to new programmes. Often they have problems in understanding that initiating new ones does not necessarily mean that all old programmes can be run down or cancelled. On the other hand, we must be secure enough in our knowledge to take responsibility for running down outdated programmes when that also is necessary.

I think there is a light 'breeze' (I hope it will become a wind) in Europe at the present time. Thoughts about standards and quality of nursing care are emerging, not only as words, but as realities. Undoubtedly the United Kingdom has advanced farthest in these areas, but other countries are following. Surely these are areas of common interest to both nursing

managers and clinical practitioners: to managers in terms of budgets, in terms of allocating resources, and in telling the public what they can expect or not expect for their money; to practitioners so that they can be accountable – to know for what they are accountable and to whom.

But they also can be areas of conflict. It is conceivable that nurse practitioners may attack nursing management for not providing the structure, the personnel, the equipment and other resources to make possible the practise of quality care. It is also conceivable that the nurse manager will feel that she is providing this to an extent that is humanly possible, but that the practitioners do not really want to assume the responsibility for improving the quality of services to individual patients, and also that the practitioner does not wish to be accountable. In addition, both the practitioner and the nurse manager will meet problems from outside – from the management team whose members fear higher costs and from other health professionals who fear that nursing is assuming a too independent, professional role. It will be extremely important that we, within the profession, find ways to make this a unifying experience rather than one which is destructive to nursing and thus, indirectly, to the health of the general public which has a right to our services.

In conclusion – yes, I think there are possible areas of conflict between the role of a professional nurse and the role of a nurse manager. At the same time, I do not believe anyone can manage nursing better than a prepared nurse manager. Some of the problems we experience may be due to a lack of information about the real experiences of our everyday working life, how we set our priorities in practice and in management, and how well we share our problems. Problems in nursing practice are the problems of the nurse manager, and problems of the nurse manager are the problems of the clinical practitioner.

Some basis for our problems may be found in the organisational structure and perhaps we should ask whether the structure in our agencies is suited to the development of a professional model. Do we trust our nursing colleagues? Do we trust our non-nursing colleagues? It is impossible to run a health care system based on mistrust. Do we understand – and accept – that although we nurses, doctors and administrators may say that we all have the same goal – serving the public – that we serve in different ways, and that each is important?

In conclusion, I have tried to highlight some of the problems or potential problems I see as a nurse manager. I have offered a few answers – and many questions of the practical kind.

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1 McMahon R and others. On being in charge: a guide for middle-level management in primary health care. Geneva, World Health Organization, 1980.
2 Peters T J and Waterman R H. In search of excellence. New York, Harper and Row, 1982.
3 Blegen and Nylen. Organisasjons teori (Organisational theory). Tapir, Norsk, Forlag, 1977.
4 Stevens B J. Nursing theory: analysis, application, evaluation. Boston, Little, Brown and Co, 1979.

DISCUSSION

Participants identified two types of possible conflict for the nurse leader:
- *intra-role* where the nurse's managerial role conflicts with his/her professional role; and
- *inter-role* where the nurse's managerial role conflicts with those of others – either other nurses or other health care workers.

It was suggested that the sources of *intra-role conflict* could be either structural or personal. Structural sources frequently gave rise to conflicting professional and organisational expectations and also to conflicting demands because of limited resources. But not all aspects of conflict were bad; often they stimulated creative development, presented room for manoeuvre and provided an area for bargaining. Many nurse managers had yet to learn to bargain with their colleagues, to negotiate and to compromise within a bureaucratic structure. Often in a managerial capacity a nurse had to compromise in a situation where, as a clinical nurse, she/he would not wish to do so. Safety mechanisms for this kind of conflict included the definitions of clear roles and goals within one's area of authority, effective communication, flexibility, innovative dynamism, and, above all, appropriate education for the job.

The group emphasised that personal sources of conflict also often resulted from the lack of adequate preparation for a position: comprehensive education for new responsibilities was crucial to success in a new role. Some participants believed that there was a lot to be said for a follow-up of academic or theoretical education by an apprenticeship kind of experience with side-by-side learning so that an experienced nurse-manager can be used as a role-model.

Personality attributes or characteristics – including set stereotyping – also contributed to conflict as did loneliness when one was the only nurse and/or woman in the situation. There had to be a willingness to 'give and take', to minimise any loss of face that occurred and to take trouble and effort to restore goodwill when it had been jeopardised or damaged.

Inter-role conflict (often in the form of 'nurses versus "the rest" ') was usually the result of competition for scarce resources – either material or symbolic. This could generate more than loss of goodwill and trust. Often it produced anxiety, frustration, anger, hostility and, sometimes, even the making of enemies.

When in competition for limited resources it was essential to be able to make a good case for nursing and for nursing resources: the need for them had to be clearly demonstrated. Qualitative as well as quantitative

evidence had to be produced and the value of anecdotal data was not to be under-estimated. In order to provide and present these data, nurse clinician and nurse manager had to collaborate, and that cooperation could help to build the essential bridge between 'leader' and 'those led'.

Another potential source of data identified by the group was research findings, but members agreed that often these were diffuse or were based on small samples. Also, frequently, it was preferable to select and present salient points rather than to report on, or to direct colleagues to, a specific publication.

The development of an international information system was discussed and it was recognised that the first requisite was to identify data which could be helpful. Collation of data alone did not solve a problem. For example, while we had numerous data on tuberculosis and malaria *and* the technology to eradicate them, to date we had failed to do so. People were not machines and health care professionals were not assembly line workers. The management and leadership structures and techniques which were successful in one setting were not always suitable for another. What data did we need, as nursing leaders, to improve nursing standards and quality? The activities constituting nursing were varied and while standards set must be acceptable to the profession as a whole, only those clinicians working in it could indicate what could be achieved realistically in a particular field. Good management must include the identification of staff interests and expertise and the utilisation of them to seek, agree, and meet objectives. If a compromise had to be made, that also had to be agreed with all members of staff: mutual trust and respect were essential in any leader/follower relationship.

Turning their attention to fostering the development of future leaders for the profession, participants believed that positive discrimination in their favour had to be practised. Many basic and post-basic educational programmes required review and amendment, as did current teaching methods. Whilst there was an urgent need in each country to activate nurses' political awareness, nurses had to differentiate between the legislative and practical changes they wished to bring about and they had yet to learn how to develop different strategies for each.

Participants also thought it would be useful to consider who it was who took executive action for change and then take steps to form coalitions and collaborative relationships with them. This was especially applicable to the nurse/doctor partnership: recent events had tended to overshadow the fact that there was more uniting the two professions than dividing them. Such rifts should be healed and mutual trust, respect and support restored.

Finally, participants recognised their own need for support as nurse-leaders, and believed that national and international networks which could fulfil this function should be set up or strengthened as appropriate. Because in the past decade the profession had undergone much fragmentation by geography, speciality and sectional interest, it was believed that a review of existing networks would provide interesting indicators for possible streamlining or extensions.

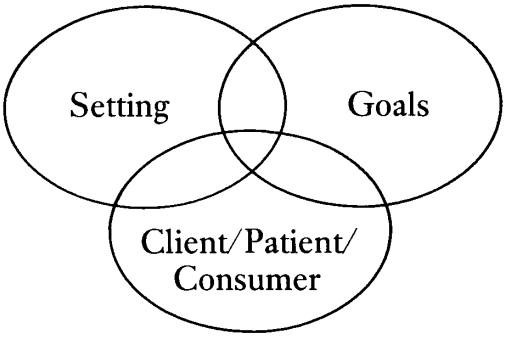
The problem of communication, agreeing goals, and sharing information within countries was also discussed and the group agreed that far more could be achieved if there were greater cooperation between national nursing organisations and governments. In the majority of countries, executive nurses were employed by each, but often, because of a lack of communication and coordination, little concerted effort was in evidence. Only when nursing resolved the conflicts within itself and spoke at government level with one voice would it be listened to and achieve political power.

QUO VADIS?

by Shirley Chater

This international seminar on nursing leadership has been set within the context of impending crisis in nursing. As health care costs continue to rise and competition within our systems sharpens, nurses must speak out and take more active leadership roles in the determination of the social and economic policies that affect the welfare of our patients and clients.

The backdrop of social, economic and political concerns against which our discussions took place can be summarised as follows:



Setting

We noted that solutions to problems or generalisations about strategy would be different, depending upon each individual setting. External factors of setting are those of the social, economic, political and geographical variables of our countries, districts and local areas. Internal variables of the specific setting in which we work are those of structure, personalities and inter-personal relationships (to name a few).

Goals

There was no argument that our collective goals and objectives as nursing leaders are to provide high quality nursing and health care to clients, patients and consumers. Nurses serve as patient advocates; undoubtedly the future will call for more explicit probing about how we can strengthen our liaison roles as patient advocates.

We noted throughout that our goals could be carried out in a variety of settings: educational, service, government, community, and others.

Client/Patient/Consumer

Any planning process, be it for educational programmes for nursing

students, or nursing care services for patients, must include increasingly detailed attention to demography. Our patient populations are growing older and our populations in general are more ethnically diverse than ever before. These and other related variables (social, philosophical, cultural), will influence both goals and settings in which those goals are carried out.

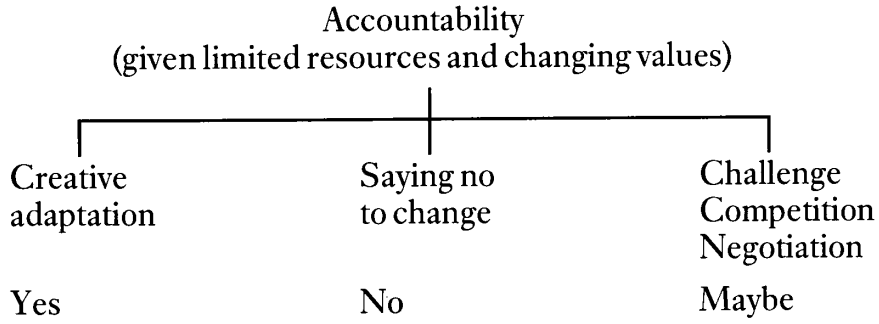
Obviously these circular areas overlap one with another suggesting the difficulty in dealing with only one aspect of the framework or backdrop against which we must examine nursing leadership.

Our programme planners selected 'accountability' as a major theme of the conference. It was noted that accountability means more than simply being responsible for our actions.

Accountability is:

- embedded in value systems and cultural expectations;
  - it involves others' expectations of one's behaviour
  - values may change over time
  - others do the judging and evaluating of our accountability
- related to the materials and resources available to us at the time we are said to be accountable;
- product (for what) and process (how and to whom) oriented.

Caroline Cox summarised our choices for being accountable given the restraints of resources by suggesting a 'yes – no – maybe' approach:



There was agreement that we had to be accountable; indeed that we wanted very much to be accountable for the highest level of nursing care, and a high level of quality of life. We agreed that we could do this more effectively if we broadened our interests beyond nursing.

Leadership

A leadership role is a set of behaviours identified with a particular position. Multiple behaviours were touched upon throughout our meetings; planning, organising, directing, coordinating, facilitating, controlling. Again the programme planners presumably considered these

behaviours to be part of our current roles, whatever they may be at present. These, the topics of power, politics and conflict resolution, were chosen as agenda items since these strategies cut across all roles and because they provide somewhat newer ways to examine old issues.

We learned that power can be used creatively to achieve a strong position in relation to others and for the solution of problems. We heard Trevor Clay differentiate between politics with a capital P and politics with a small p, while he urged us to become more active in both kinds. Martha Quivey enumerated a variety of sources of conflict and provided many suggestions for bringing about conflict resolution.

A most positive outcome of our exchange of ideas and accounts of progress was a list of many exciting endeavours now underway in many of the countries represented here.

1 The delineation of standards for nursing practice.
2 Continuing research activities to provide a scientific base for practice.
3 Demonstrative projects to describe outcomes of nursing care.
4 Increased participation in government and public fora as nurses and citizens.
5 Increased participation in social and health policy planning.
6 Telling our own story – with pride, confidence and evidence of outcomes.
7 Standing up to the rights and privileges bestowed upon us through our licences and through the positions we hold.

Group discussions elicited many more examples of leadership activities and many of the participants expressed the request to hear more about specific projects and progress during future opportunities such as this one.

Nearing the end of the seminar, the groups listed eight suggestions for follow-up activities. This was developed with the enthusiastic hope that we, who now constitute a peer-colleague group, would have the pleasure of meeting again to continue discussion, to motivate each other and to offer support for the potential difficulties that lie ahead.

In bringing this seminar to a close, I would remind participants that optimism is a better motivator than pessimism. I would encourage you to look at our cup not as half empty, but as half full. Our sense of who we are has been heightened during this seminar, our self-awareness along with our commitment to responsibility and accountability has been increased.

May I leave you with the thought of Fritz Perl: 'Self-awareness is the responsibility of *knowing* and *using* what one *is*'.

AN APPRECIATION

During the final session, participants expressed their appreciation and thanks to the King Edward's Hospital Fund for London and to the Royal College of Nursing for the generous hospitality received and for the opportunity to acquire new knowledge, which in itself, was power for leadership.

The group recorded its gratitude to the Secretary of the King's Fund, Dr Robert Maxwell and to Miss Hazel Allen, Assistant director, King's Fund Centre, to Miss Margaret Green, Director of education, Royal College of Nursing of the United Kingdom, and their staff for all the work entailed in organising the seminar.

PARTICIPANTS' SUGGESTIONS FOR FOLLOW-THROUGH OF THE SEMINAR'S DELIBERATIONS

1 *Early identification of potential nurse-leaders.*
There should be positive discrimination in the development of those nurses identified as potential leaders and exciting, dynamic and pertinent training programmes slanted to their special needs made available to them.

2 *The promotion of political awareness among nurses.*
Political awareness among nurses could be developed through:

- basic education programmes;
- post-basic education programmes for nurse-clinicians, educators and managers;
- the development of political structures and processes.

3 *The development of political power bases.*
In the first place, political power bases could be established by forging links with Members of Parliament and local political figures. (In this connection, participants considered it important to differentiate between legislative and political goals and activities.)

4 *The establishment of collaborative relationships with other professional healthworkers.*
The establishment (or re-establishment) of collaborative relationships and social fora with non-nurses should aim to heal existing rifts and to form coalitions with members of other professions (especially doctors) to negotiate, to achieve common goals, and to assist one another in the attainment of objectives identified by their respective professions.

5 *The promotion of knowledge about the role of government nurses.*
So that in each country nursing can speak at government level with one strong voice, ideas, opinions and viewpoints of national professional organisations/associations should be coordinated with those of government nurses. At the present time, there is, among the majority of nurses, little knowledge of the role of government nurses: information on this should be included in basic nursing curricula.

6 *The development of national and international nursing networks.*
The development of national and international nursing networks – using international federations and organisations such as the International Council of Nurses and the World Health Organization – would provide the mechanisms to facilitate the sharing of information on nursing and nurses and to strengthen the supportive structure necessary for the promotion and exercise of nursing political power. (It was suggested that

a preliminary review of the already existing nursing networks would be helpful so that strengths and weaknesses could be identified, and participants hoped that the organisers of the seminar, King Edward's Hospital Fund for London, might consider undertaking this task.)

7 *Executive action to establish a nursing 'think-tank'.*

Regular meetings of top-level nurses from a number of countries, together with nursing representatives of organisations/federations such as WHO and ICN would provide a forum for discussion of, and agreement on, nursing, healthcare and social issues of mutual importance and interest. (Participants recognised that further consideration would need to be given to possible sponsorship and the servicing of such an international group.)

8 *Organisation of a follow-up seminar.*

A follow-up seminar in about two years' time (not necessarily with the same membership nor the same venue), would enable further development of international thinking among nurses. Items suggested for its agenda included:

1 Party politics: political policy and procedure for nurses.
2 Nursing contributions to health and health policy.
3 The legal responsibilities of nurses.
4 Working with patients – and other pressure groups.

Additional suggestions for the agenda and also for the choice of venue will be sent to Miss Margaret Green at the Royal College of Nursing by 1 January 1985.

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APPENDIX I

International seminar on nursing leadership
King's Fund College, 2 Palace Court, London W2

Programme

Monday 29 October 1984

18.30 Evening reception: welcome and address by Robert J. Maxwell JP PhD Secretary to King Edward's Hospital Fund for London

Tuesday 30 October 1984

Chairman: Miss Sheila M. Quinn CBE, President, Royal College of Nursing of the United Kingdom

09.30 Introductory paper: *Accountability, leadership and nursing.* Dr Shirley Chater, council associate, Division of Academic Affairs and Institutional Relations, American Council on Education, Washington DC

10.30 Coffee

11.00 Questions

11.30 Prepare afternoon work and start group work

13.00 Lunch

14.00 Group work

16.00 Free time

17.30 Plenary session: *Discussant's analysis of group work.* The Baroness Cox of Queensbury

19.00 Dinner

Wednesday 31 October 1984

Chairman: Dr Amelia Mangay-Maglacas, senior scientist for nursing, Division of Health Manpower Development, World Health Organization, Switzerland

09.00 *Nursing and Politics.* Trevor Clay, General Secretary, Royal College of Nursing of the United Kingdom

10.00 Questions

10.30 Coffee

11.00 Group Work

13.00 Lunch

(Afternoon free)

19.00 Dinner

20.00 Plenary session: *Discussant's analysis of group work.* The Baroness Cox of Queensbury

Thursday 1 November 1984

Chairman: Mrs Rosemarie Weinrich, executive director, Professional Nursing Association, Frankfurt, Germany

09.00 *Conflict of leadership role and professional role.* Mrs Martha Quivey, Director of Nursing Services, Oslo, Norway.

10.00 Questions

10.30 Coffee

11.00 Group work

13.00 Lunch

(Afternoon free)

16.00 Plenary session: *Discussant's analysis of group work.* The Baroness Cox of Queensbury

Formal farewell dinner at the Royal College of Nursing of the United Kingdom

Friday 2 November 1984

10.00 Coffee

10.30 Closing address: *'Quo Vadis?'* Dr Shirley Chater

13.00 Lunch

APPENDIX II

List of participants

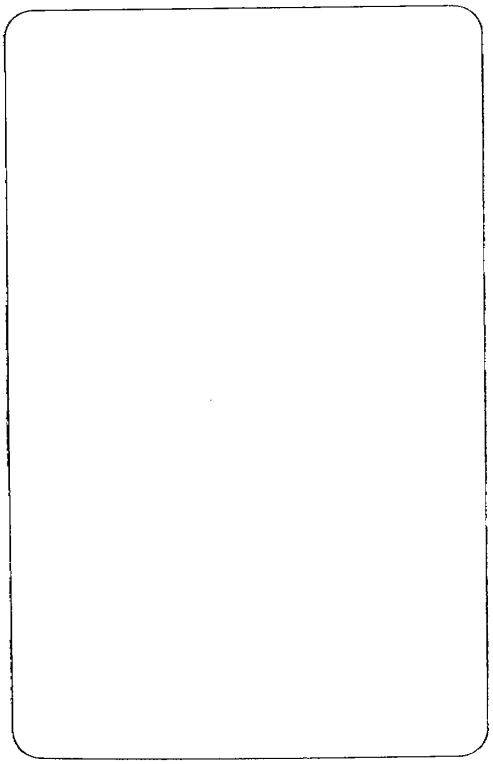
Dr Shirley Chater	Council associate, Division of Academic Affairs and Institutional Relations, American Council on Education, Washington DC, USA
Mr Trevor Clay	General secretary, Royal College of Nursing of the United Kingdom, London, UK
Dr Marie Farrell	Officer for Nursing, World Health Organization Regional Office, Copenhagen, Denmark
Mr T. Gypen	Director of nursing services, University Hospital Antwerp, Edegem, Belgium
Miss Constance Holleran	Executive director, International Council of Nurses, Geneva, Switzerland
Miss Vassiliki Lanara	Director of nursing, Evangelismos Hospital, Athens, Greece
Miss Mary Laurence	District nursing officer, West Lambeth Health Authority, London, UK
Miss Ingibjörg R. Magnusdottir	Chief nursing officer, Ministry of Health and Social Security, Reykjavik, Iceland
Dr Amelia Mangay-Maglacas	Senior scientist for nursing, Division of Health Manpower Development, World Health Organization, Geneva, Switzerland
Mrs Yvonne Moores	Chief nursing officer, Welsh Office, Cardiff, UK
Miss Carmen R. Netzel	Director of nursing services, University Hospital, Barcelona, Spain

Miss Sheila M. Quinn	President, Royal College of Nursing of the United Kingdom, London, UK
Mrs Martha Quivey	Director of nursing services, Oslo Helserad, Oslo, Norway
Ms Inga-Maja Rydholm	Chief nursing officer, University Hospital, Linköping, Sweden
Miss Julita Sansoni	Executive secretary, National Association of Nurses, Rome, Italy
Miss Suzan de Vlas	Treasurer, National Nurses Association of Holland, Woerden, Holland
Mrs Rosemarie Weinrich	Executive director, German Professional Nursing Association, Frankfurt/Main, Germany

Discussant The Baroness Cox of Queensbury

Rapporteur Miss Muriel Skeet, International nursing and health services consultant

Seminar coordinators Miss Hazel O. Allen, Assistant director, King's Fund Centre
Miss Margaret D. Green, Director of education, Royal College of Nursing of the United Kingdom

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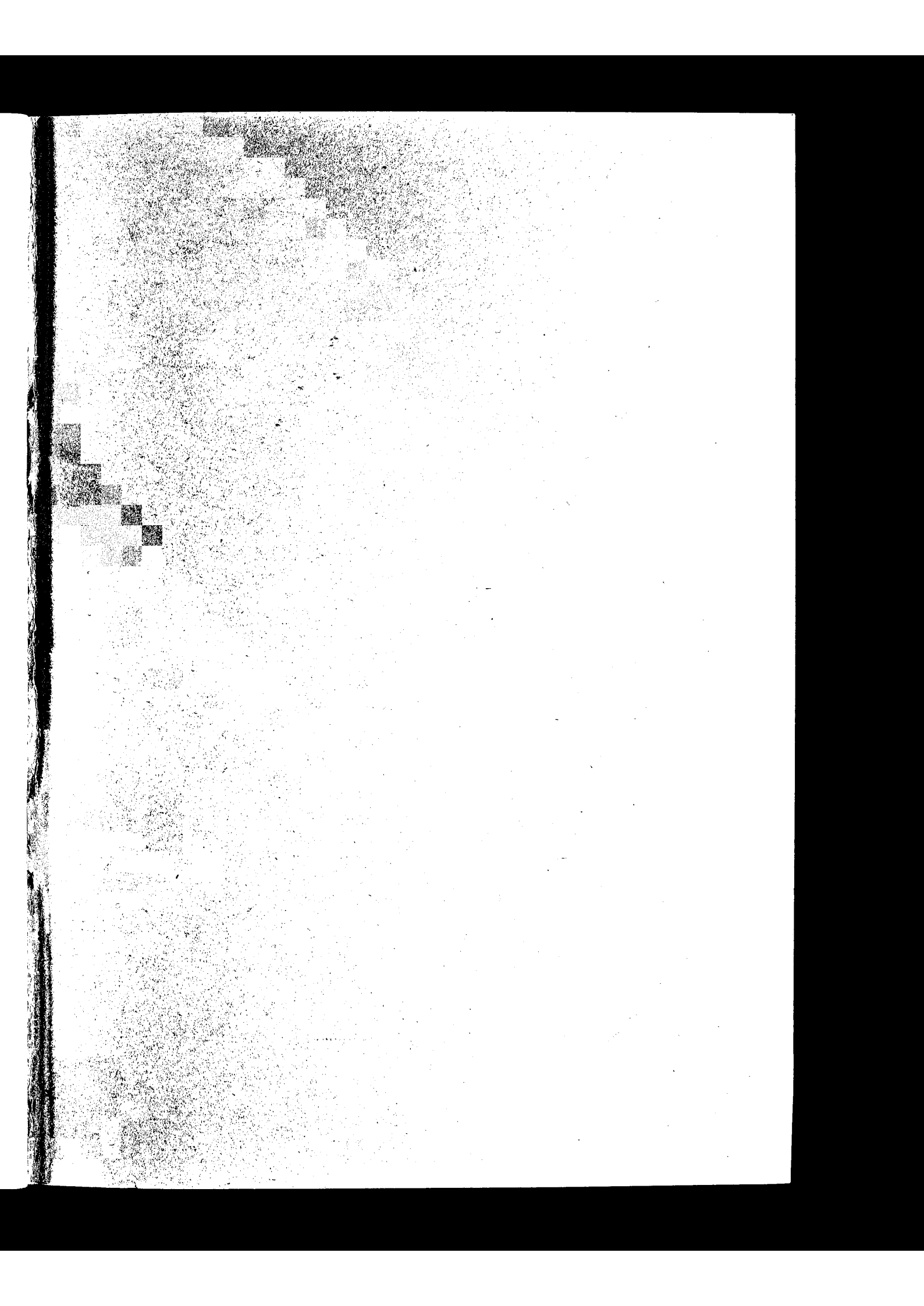

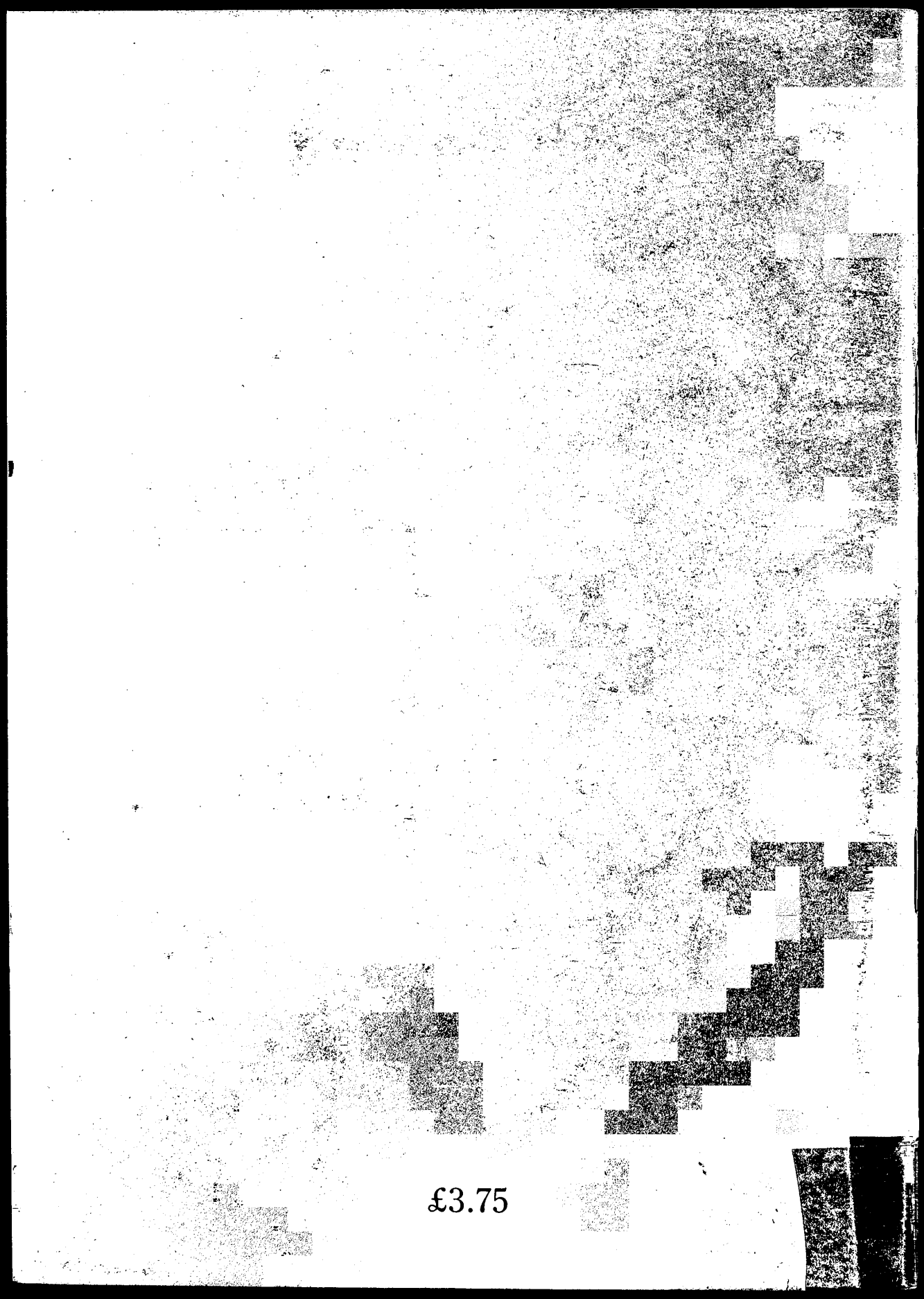

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