Nursing Leadership for Patient-Centered Care

AUTHENTICITY • PRESENCE • INTUITION • EXPERTISE

Harriet Forman, EdD, RN

“Dr. Forman’s book is revolutionary and courageous in that it brings to light negative issues that exist in nursing management and patient care....Her use of plain, day-to-day language and methods will ultimately bring reform to health care at the bedside.”
—Deborah M. Tascone, MS, RN
Regional Executive Director
North Shore Long Island Jewish Health System

Too often, both nurses and patients witness major breakdowns in the health care system—ineffective communication, unrealistic nurse-patient ratios, tension among staff, abuse of authority, and most importantly, managers drawn away from patients due to administrative duties. This inspiring guide presents engaging, real-life stories of nurses, managers, and leaders who have experienced failures of the system firsthand, and have been motivated to critically examine, address, and resolve them.

This collection of narratives includes practical methods, models, and strategies that nurses can apply to enhance and expand their own practices. Readers will gain a wealth of insight on how to overcome narrow-mindedness and egocentrism, to improve their management, leadership, communication, and organizational skills, and ultimately to bring real reform to health care practices and patient care.

KEY FEATURES:
• Presents stories of actual management issues and how nurse leaders/managers, nursing staff, and patients have handled them
• Identifies harmful trends in the health care system that can be analyzed and remedied
• Encourages nurse managers to shift the prevailing system-centered orientation to one that is patient-centered
• Provides a phenomenologically based leadership/management model for resolving nursing issues institutionally and individually
• Includes methods for addressing cultural and religious barriers among staff

An engaging, enjoyable read, this book will empower readers to dramatically transform the health care system at large.

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11 W. 42nd Street
New York, NY 10036-8002
www.springerpub.com

NURSING LEADERSHIP
FOR PATIENT-CENTERED CARE

Authenticity Presence Intuition Expertise
Harriet Forman, EdD, RN, is a well-known nurse leader, educator, published author, and editor of the Cherry Ames series of books. She is a specialist in communication, management and leadership development, redesign, and patient-centered care and team building as critical components of patient and staff satisfaction and retention. She has been a chief nurse executive of both acute and long-term care facilities and worked with Nursing Spectrum in various executive and editorial positions, including launching the New York/New Jersey division, serving as executive director for the Florida division, and fulfilling corporate executive and editorial responsibilities. She also participated in launching what is now Healthcare Traveler magazine. Dr. Forman coauthored a labor relations column published over a 2.5-year time period in Journal of Nursing Administration, as well as many professional articles and a chapter on collective bargaining in Leadership and Nursing Care Management edited by Dr. Diane Huber.

Her previous experience comprises both clinical and administration. Dr. Forman's teaching practice includes adjunct graduate faculty lecturing at several universities and continuing education instruction to groups as large as 1,200 participants. She is widely published and is a member of nursing and health care leadership-related organizations including Sigma Theta Tau. Dr. Forman has been accepted as a National Labor Relations Board expert witness in labor relations and managerial communications and as a Florida federal court expert witness in nursing administration. She worked internationally with health care, nursing, and medical personnel in Russia and addressed the first Congress of the All Russian Nurses Association in Saint Petersburg. She is a board member and senior consultant for The Center To Promote Health Care Studies, a Distinguished Alumnus of The Mount Sinai Hospital School of Nursing Alumni Association, and has her professional collection archived at the Center for Nursing History, Guilderland, NY, on invitation from the Foundation of the New York State Nurses Association. Her education ranges from a diploma in nursing from The Mount Sinai Hospital School of Nursing to a Doctorate in Education with a focus on the Nurse Executive Role from Columbia University Teachers College.

Foreword by Deborah M. Tascone

Deborah M. Tascone, RN, MS, is regional executive director of the North Shore-Long Island Jewish Health System located in the New York City metropolitan area.
She is responsible for multiple acute care hospitals within the system. Ms. Tascone joined the health system as a nurse director in 1995 and was the first registered nurse and first woman to be appointed as a hospital executive director. Prior to that, she was employed in various health-related positions, applying her clinical background to the development of new programs and services throughout the hospitals for which she is responsible.

Ms. Tascone is a member of the American College of Healthcare Executives and is the president of the board of directors of Project REAL (Residential Experience in Adult Living). She has been a guest speaker for Healthcare America’s conference: Customer Service for the Healthcare Industry, where she presented on the topic “Healthcare Reform: Leadership from the Front Lines.” She has also guest lectured at Sweden’s Helsingborg Hospital and Uppsala University on the role of the CEO in the integrated health care system. In 2007, she attended the World Health Executive Forum in Montreal, Canada, where international health care leaders and government officials discussed “Strategic Health Issues—Global Vision.”

Ms. Tascone epitomizes a patient-centered health care professional who is well-known for her intuitive, empathetic staff and patient relationships.

*Prologue by Patricia Munhall*

**Patricia Munhall, EdD, ARNP, PsyA, FAAN,** is a Fellow of the American Academy of Nursing and a former professor of nursing and nurse administrator in several universities from New York to Miami, Florida, has concurrently been in practice as a psychoanalyst. She received her doctorate in nursing from Columbia University and graduated from the Academy of Clinical and Applied Psychoanalysis. She is an international speaker on phenomenology as a research method, psychoanalysis, and human understanding. Dr. Munhall is also an author or editor of 11 books and over 70 manuscripts and chapters focusing on qualitative research, unknowing, phenomenology, and philosophical analysis. The latest is the fifth edition of *Nursing Research: A Qualitative Perspective.*

Dr. Munhall is founder and President of the International Institute for Human Understanding, headquartered in Miami, Florida. The Institute, a not-for-profit organization, exists to foster compassion, tolerance, and justice ([www.iihu.org](http://www.iihu.org)). In addition to her other works, Dr. Munhall consults for qualitative research and speaks on phenomenology at workshops and conferences, and she engages in continuous active publishing on qualitative research methods. She currently resides in Miami where she has a full-time practice as a nurse practitioner and psychoanalyst.
Chapter 7 by Barbara Stevens Barnum

Barbara Stevens Barnum, PhD, RN, FAAN, is a noted presence in nursing education. She is the author of 11 books—many with numerous editions—with chapters in many other titles (five published by Springer), and of countless peer-reviewed articles. She has served as editor, Nursing Leadership Forum (Springer) and editor, Nursing & Health Care, NLN (the previous incarnation of NLN’s Nursing Education Perspectives). She is currently a consultant, psychotherapist, and part-time faculty and periodic lecturer at NYU College of Nursing. Previous positions include director, Division of Health Services, Sciences and Education, Teachers College, Columbia University, New York, where she also held the Stewart Chair and chair in the Department of Nursing Education. She was a consultant at Columbia-Presbyterian Medical Center, New York, and her first academic position was as professor, Nursing Administration, College of Nursing, University of Illinois, Chicago.

A Fellow of the American Academy of Nursing, Dr. Barnum has worked extensively, both nationally and internationally, as a continuing education instructor and consultant, including an 8-year term as consultant to the U. S. Air Force Surgeon General. Dr. Barnum presents workshops in areas of complementary medicine and spirituality nationwide.
NURSING LEADERSHIP FOR PATIENT-CENTERED CARE

Authenticity Presence Intuition Expertise

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**NOTE:** CNE—Chief Nurse Executive: The author recognizes that it is unlikely that the chief nurse executive will be the individual to lead the many activities this position is depicted as personally directing and controlling. The reader is invited to substitute any management team member for CNE as appropriate to the individual organization.
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Foreword

REFORMING PATIENT CARE FROM THE BEDSIDE

I have been blessed to practice nursing for over 30 years. The profession has been a gift that I have embraced with open arms. It has afforded me the ability and opportunity to ease the suffering of others, nurture wonderful friendships, and experience the stability and spirituality of who I am. This devotion also brings with it commitment and responsibility as a patient advocate—never turning away from what we nurses believe is right and never compromising patient care for politics or self interest. I have often said that the day I fail to hear a patient’s call bell or request for assistance will be the day that I can no longer call myself a nurse.

First as a staff nurse and then as a nurse leader at various management and administration levels, I have seen nurses become better educated and better paid than ever before. But often drugs and supplies are not available to them when and where they need them. They spend precious time and energy running to pharmacy and to central supply. Often they also have to transport patients instead of providing and directing patient-centered care. Nurses also face the challenge of duplicative paperwork, excessive mandatory meetings, and burgeoning regulations and responsibilities.

At the same time, all too many patients and potential patients speak of hospital experiences with apprehension. Hospital-acquired infections and other iatrogenic conditions are of concern, nursing shortages and the uninsured make headlines, emergency centers overflow, and disgruntled staff members cause labor/management unrest.

Health care reform has occupied the hearts, minds, and halls of congress—seemingly forever. But another kind of health care reform is also needed—in how care is delivered at the bedside.

Among the problems to be solved are impractical nurse/patient ratios; unanswered call bells, especially on nights and weekends; redundant efforts; task orientation; ineffective communication; shifting priorities; managers drawn away from patient-centered care by administrative duties; and tension between and among staff from different cultures. These and other issues impact negatively on both the staff and patient experience, as well as on outcomes.
In her book, *Nursing Leadership for Patient-Centered Care*, Dr. Forman approaches these issues not as an outsider looking to place blame, but as a nurse executive who appreciates nursing and its practitioners—as a nurse-oriented consultant and a nurse leader who has applied practical approaches to improve situations inimical to both patients and staff alike. She leads from within—from a patient-centered, empathetic perspective that allows the manager to feel what it is like to live the experience of staff and patient. I know this to be true of her from personal experience—from having worked with and been mentored by her.

Dr. Forman’s book is revolutionary and courageous in that it brings to light negative issues that exist in nursing management and patient care. Without change, these will only worsen.

From the first chapter to the last, Dr. Forman cites actual examples that demonstrate such things as a nurse turning her back on a patient with a bleeding wound saying, “I can’t intervene without MD’s orders.” Or of nurses concerning themselves with pedantic rules rather than patients’ comfort, racial and religious prejudice causing fulminating hatred that spills out into the patient care arena, favoritism influencing promotions and discipline, and power and authority being abused and misused.

Dr. Forman’s work is steeped in theory. She steps outside traditional avenues of study and delves into ancient philosophy, existential psychology, and other intellectual learning realms. She captures readers’ imagination and expands their horizons to help them understand their staff members’ and patients’ life experiences.

The born leader theory takes a prominent position, along with a focus on the magnetism of charisma as a driving force of leadership. She shows us how we can learn from such notable figures as Christ and Gandhi. Among the other theories she draws from are communication theory, leader behavior style, motivational theory, critical thinking, personality theory, philosophy, ethical decision making, collective bargaining, power and authority, management, leadership, and the organization. Importantly, Dr. Forman’s approach is effective application of theory to practice.

Dr. Forman has captured the very essence of the problems that are holding back the patient-centered relationships of nurses, nurse managers, and the interdisciplinary team. Her use of plain day-to-day language and methods will ultimately bring reform to health care at the bedside—where it is essential to the lives of those we serve. This book has the potential to revolutionize nursing management and patient-centered nursing care with
the most honest appraisal of what is actually transpiring in many of our centers of care.

Through the examples of breakdowns in care and frank discussion, Dr. Forman describes and dissects common problems. She then reconstructs a stronger, sturdier patient-centered model—one that will withstand scrutiny and the sands of time.

Why this book is essential for every nurse manager and aspiring nurse manager to read: Nursing Leadership for Patient-Centered Care is a page turner. Reading this book, nurses may have Aha! moments. It should be thoughtfully read and carefully considered. The ideas put forth need to be discussed: staff and management should be mentored and given time and opportunity to grow, develop, and give personal tension and prejudice the light of day without fear of criticism.

None of this can be done overnight. As we know from trying to reform the greater health care program in the country—true reform takes time, effort, support, consensus, and commitment. Dr. Forman has drawn the new paradigm. Her organizational chart is concentric—the patient is at the center. Now it is up to dedicated nurse managers, leaders, and academics to make it a reality.

Deborah M. Tascone, MS, RN
With gratitude, I acknowledge the individuals listed below. Without their influence, I probably would not have been able to write this book. I apologize to those I may have inadvertently omitted.

**Allan Graubard**—executive editor, Springer Publishing Company. When I brought my idea for this book to Allan, he had the vision and the courage to see merit in a new way to tell an old story. I owe to Allan a world of thanks for advancing my proposal to the publisher.

**Florence VanKeuren, MS, RN**—former executive director, Visiting Nurse Association of Long Island. I came to her with no applicable clinical experience. Nevertheless, she recognized my potential and employed me; she identified my propensity to function independently; she assigned me accordingly and set me on my life’s path.

**Sonya Hirschberg, MS, RN**—former director of nursing who took a leap of faith and placed me in an administrative position, then mentored me in labor relations and management. She taught me that it was okay to sidestep regulations to serve the greater good.

**Rachel Rotkovitch, MS, RN, FAAN**—former CNE who understood and used power in creative ways. Although I never worked for her, I learned an enormous amount from her. Without her personal reference, I would not have landed my next job—as director of nursing at a large, complex medical center in Brooklyn.

**Margaret McClure, EdD, RN, FAAN**—professor, former CNE, and author of *Magnet Hospitals: Attraction and Retention of Professional Nurses*. Maggie, as she is fondly known, mentored me in several important labor relations areas that I had not yet encountered. She also helped me appreciate the inherent power of time and the fine art of persuasion.

**Suzanne Smith, EdD, RN, FAAN**—editor-in-chief, *Journal of Nursing Administration (JONA)* and **Leah Curtin, ScD(h), RN, FAAN**—former editor *Nursing Management*; founder *CurtinCalls*; editor emeritus *American Nurse*. Truth be told, I dreaded what they did but appreciated the effect it had upon me. Both of these professional writers/editors took pen in hand and scrupulously edited my early works.

**Kevin W. Smyth**—founding publisher, *Nursing Spectrum*, who employed me to start the New York/New Jersey division of *Nursing Spectrum*. 
Within a few weeks, he taught me what I needed to know about bulk mailing, type setting, printing, and all the myriad details of magazine production and sales to produce a nursing publication. I stayed with the company for 12 years, during which time I met the next person to whom I give thanks.

Robert Wells—who entrusted me with the copyright to the Cherry Ames series of nurse books written by his sister Helen Wells. My mission was to return these books to the marketplace to make them available to nostalgic past readers and, importantly, to today’s young readers. Thanks to Springer Publishing, these books are “for sale.”

My parents Frances and Herman Schulman—who taught me fairness and love of humankind. They raised me in an environment rich with music, poetry, literature, and charitable giving. This established a basis for my pursuing a career in the healing art of nursing—and in writing and publishing.

Joseph (Rsh) Rosenman and Meryl Tihanyi—my son and daughter, who both still try to teach me patience. Funny how as the years go by, roles reverse, and the teacher becomes the student and the student the teacher. Empathy runs deep in them both. I like to think they got that from me.

Sol Forman—listed last but certainly not least—my dear husband: always encouraging, never unwilling to toss around ideas with me, my first and last reader, and the person I count upon to edit out my vestigial purple prose.
Introduction

As you prepare to commit some of your precious time to reading Nursing Leadership for Patient-Centered Care, you might want to know something about me—its author. So allow me to introduce myself.

First and foremost, I am a nurse who loves my profession. I have cared for and advocated for patients and for nurses and our line of work throughout a long and fruitful career. During this time, I launched the New York/New Jersey division of Nursing Spectrum and served in several corporate editorial and administrative leadership positions. I also helped start Healthcare Traveler—a publication for traveling health care professionals.

Before that, I was a chief nurse executive of acute and long-term care facilities, adjunct professor and continuing education instructor, author, and consultant in the United States and in Russia. During these years I conducted innumerable conferences and have spoken with professional nurses in many specialties and at all levels of education and experience. Patients, members of the nursing and the interdisciplinary team, and others in hospitals and long-term care facilities shared their knowledge, opinions, outlook, and recommendations with me.

They have told me many stories. Some have been about wonderful care—about nursing interventions that have saved lives, brought comfort to the dying, and joy to the living. But there are dismaying stories, too, of unnecessary deaths due to inadequate follow-up by nursing supervisors, physicians who did not believe nurses reporting patients in danger, and nurses who did not believe support staff telling of similar events. I have heard of comatose patients aspirating because of poor positioning, and pressure injuries eroding flesh and bone of patients on one-on-one care in ICUs. I have listened to narratives from patients awaiting drugs to ameliorate excruciating pain while nursing staff and pharmacists debated drug delivery responsibility.

During my adjunct faculty experience, I interacted with nurses in the relative quiet of the classroom where ideas could take wing and develop. But students in a classroom—and many of their professors—cannot relate to what it is like to practice in the often hectic environment of the health care delivery setting, where hundreds of patients require care during a hurricane, blizzard, strike, or some other unexpected event that tests the
planning, implementation abilities, and mettle of leadership, management, and staff.

Throughout my peripatetic experiences, I observed many things and listened carefully to both people who received care and provided care. As an administrator, or a consultant applying research to practice, I led change from more traditional, ubiquitous hierarchical or matrix models of care to patient-centered versions. There, iatrogenic patient breakdowns such as contractures, shearing and pressure injuries, and hospital-acquired infections were cause for concern long before Medicare imposed reimbursement penalties for such conditions. Our motto was “if we can cure them, we could have prevented them in the first place.”

As I spoke to literally thousands of health care professionals and visited health care organizations—acute, long-term, voluntary, proprietary, university-based, and community-based—the same essential factors began to stand out. These are described below, and they are the factors upon which I have based this book.

**Essential Factors**

1. Empathy—the ability to walk a mile in the shoes of another—be it subordinate staff, peers, and especially patients, was glaringly deficient, especially where hierarchies and intercultural prejudice prevailed. Philosophically, and in practice, there was an absence of sensitivity to others’ hurt feelings because of pecking orders, which resulted in the will to “get back.” This resulted in labor unrest, collective or insidious reactiveness, and other negative types of lateral or downward violence.

2. The three Cs—collaboration, cooperation, and communication—were not regularly practiced between and among nurses and other entities within the health care setting. Patient-centered care was consequentially fleeting. As an example, nurses and nursing personnel were often out of synch with each other. Instead, there was rivalry and lack of mutual respect among nursing team members as well as between nurses and physicians. A philosophy known as phenomenology—whereby an individual places oneself in another’s position and asks how it feels to be that person (e.g., patient or a subordinate staff member)—was often absent from the patient-care setting, where egocentricity seemed to be the norm.
3. Patients and patient care were not the center of attention, despite mission and goal statements that identified them as such. Job descriptions were road maps to form and function that sometimes circumscribed and limited action. This often resulted in “It’s not my job syndrome.” Organizational charts were hierarchical with power and communication flowing from the top down. This led to breakdowns in communication and cooperation. Importantly, nurse managers—middle and upper—were “visibly absent” from patient care areas—some were completely unknown to staff. Few practiced dynamic management by wandering around (MBWA). Much time was wasted at meetings and on office work. In many cases, punitive management methods prevailed. There were hierarchies in which relationships between entry-level staff and RNs were damaging to lower-level employees’ egos and therefore to patient-centered care.

4. Effective labor relations. Adversarial relationships are detrimental to patient-centered care. Management should fully understand their labor agreements and not breach its tenets. In many cases, management personnel had not even seen a labor agreement. They were often intimidated and browbeaten by aggressive union delegates. Sometimes they developed and held grudges against their own staff members long after they had participated in a labor action against their organization. Proper handling of grievances and discipline, performance appraisals, anecdotal records, and other concerns that impacted personnel issues was sorely lacking. Sometimes the notion of making the union a partner in patient-centered care was thought of as a novel idea rather than a goal.

5. Cultural and religious differences needed to be bridged. Favoritism based on race, creed, and national origin was evidenced by supervisory personnel. This often resulted in unfair scheduling and promotion practices. Also, there was intolerance and sometimes palpable hatred among staff members and toward patients. To complicate matters, patients and visitors sometimes demonstrated bigotry toward staff members who were not counseled in handling this appropriately. The need for education and mentoring in dealing with this complex issue from all aspects was compellingly clear.

6. Individuals were being assigned to responsibilities, tasks, and positions with little or no thought to personality traits. For example, “adventurers”
were skipped over for exciting new challenges and “homebodies” were selected to float. This frequently led to negative satisfaction levels, belligerent behavior, poor team building, and unsuccessful outcomes. Patient-centered care and individual staff members suffered and reacted negatively as a result. Management staff failed to understand the reason for unrest and lack of success.

7. Critical thinking, ethical decision making, morality, and power and authority all required further attention. When confronted with complex problems, many individuals seemed ill equipped to take the intellectual steps necessary to reach long-lasting solutions. Ethical decision making appeared to be linked to an individual’s personality rather than to ethics as a scholarly matter. People had difficulty separating morality from legality. There was little time to spend on formal education regarding these important issues, and mentoring opportunities were unrecognized. Power and authority were too often misused and abused, thus making full circle back to issues of ethics, morality, and critical thinking.

8. Spirituality—handled therapeutically in that nurse, patient, and manager were at same levels of spiritual development—was rare. Chapter 7, “Spirituality and Nursing: Challenges, Dilemmas, and Occasional Successes,” is contributed by a noted researcher in the field: Barbara Stevens Barnum, PhD, RN, FAAN.

9. Grief—the deeply human response to suffering and loss—could have been better handled, whether it was exhibited by a patient or a staff member. Sometimes it was ignored; sometimes it was intellectualized; sometimes personal belief systems were imposed upon others despite resistance. Sometimes it was assuaged with grace and comfort. The bottom line is, I saw it often enough to include it in this book as part of a trilogy: cultural issues, spirituality, and grief. Because in the world of illness and health I have traversed, grief has gone hand-in-hand with life in all its permutations.

10. The term nursing itself needed to be more clearly defined. If you ask nurses what they do, rarely will they say, “I save lives” or “I administer skilled essential care that returns patients to optimum levels of function.” Nor are you likely to hear, “I restore health and well-being, and I provide comfort and care for the elderly,” or “I ease pain,” or “I support rehabilitation,” or “I assist the dying in making their transition,” or any of the myriad of vital, indispensible services that nurses provide almost
as second nature. What many will say is task oriented—“I give meds,” or “I provide wound care,” or “I do everything someone else doesn’t do,” or “I do all the scut work,” and so forth.

What is almost a given is that nurses will not quote either the International Council of Nurses (ICN) or the American Nurses Association (ANA) definition of nursing, which will be discussed further in the epilogue. It is so much jargon that is hard to read, a mouthful to say, and difficult to apply. Perhaps it is good for the classroom, but the classroom is not good enough for the practice environment. Neither is it good enough for nurses to explain to the public with any degree of confidence that they will be understood and respected for the vital role they play, and that is another reason I have written this book. Although in some parts of the country nurses are earning well, overall, nurses have not achieved the status or pay rates richly deserved—congruent with the important contribution nurses make to society. Further, I believe that simpler is better. Let us tell it like it is in language that is understood by the broadest segment of our own practitioners and to society.

This book addresses these essential factors and more. Although it is written from the bedside, it is strong on theory, with phenomenology being the overarching hypothesis. The framework is theoretically sound—praxis prevails.

A contribution is made by noted author and educator Patricia Munhall, EdD, RN, PsyA, FAAN, who explains the theoretical foundation of this book—phenomenology—in the prologue. Who better to enlighten the reader about what it is like to walk a mile in another’s shoes than someone who is noted for her research and writings in this field?

Much of what I have written is from observation and interaction with patients, nurses, nurse managers, entry-level and interdisciplinary staff, colleagues, administrators, and physicians, friends and family members as well as from personal experience during my work life and educational and consulting experience. Nothing has been fabricated.

Because a large percentage of nursing still is comprised of women, I have used the pronoun she throughout the book. This in no way is meant to discount or disrespect the major and increasing contribution to nursing and to patient care made by our male counterparts. It is just that he/she or she/he is awkward and a mouthful if someone chooses to read Patient-Centered Care . . . aloud.
It is my sincere hope that readers will enjoy reading *Patient-Centered Care* and that it will become a source of information that can be applied to, and improve, practice.

**Nursing—An Influential Profession**

There is just one more thing I would like to say by way of introducing myself to you as you prepare to spend some time with me. What follows is my first foray into nursing. This is when the idea entered my mind and never left. It is why I decided to become a nurse in the first place.

When I was about 8 years old, I started reading the Cherry Ames nurse series of books. I found the stories exciting and motivational. I was already the kind of kid who liked to fix people and pets. Blood and gore did not repel me—they fascinated me. So my mother gave me an anatomy and physiology book with transparent overlays. Its medical aid section taught me a lot about stanching blood and disinfecting wounds. She hoped it would motivate me to become a doctor. But Cherry and nursing always won out over every other thing that came my way.

Ideas like, “The first duty of a nurse is always to her patient,” struck my altruistic core; “spending extra time with sick and injured children and practicing holistic nursing” seemed the right thing to do—even though I had to look up the word holistic.

Cherry learned that part of holistic nursing included “psycho-neurological nursing,” and so did I. When I discovered that Cherry had a “propensity for bending the rules,” I felt a kinship with her. When I learned of her curiosity, intelligence, and courage, I aspired to be described in those terms. Finally, I learned that nursing was a profession of influential women—just like the family in which I had grown and developed.

At 17, I entered nursing school and have stayed with the profession ever since. Never have I regretted that choice. During the ensuing decades, I have seen examples of superb nursing care that has healed body, heart, and mind. I have observed nurses help patients replace fear with hope and assist individuals, families, and populations regain health and optimism they never thought possible.

But there are always two sides to every coin. As humanistic professionals, we deserve to rejoice in the excellent service we provide, in the wonderful work we do, in the superhuman effort we offer to those who come to us
for care no matter their race, religion, national origin, or ability to pay. But we also must be willing to examine our failures as well. In truth, the only way we can define and perpetuate what is good is by knowing and understanding what is bad.

_Nursing Leadership for Patient-Centered Care_ is a practical approach to fixing what is broken. It is not meant to denigrate or insult a quality profession essential to the health and welfare of individuals and the greater society—or its individual practitioners. To do that would be to denigrate myself. But to ignore breakdowns in care is to allow them to self-perpetuate. It also risks having patients endure substandard care and to dread facing institutional encounters.
Prologue

Listening With the Third Ear: Or—The Philosophical Underpinnings of This Book

Patricia Munhall, EdD, ARNP, PsyA, FAAN

In the beginner’s mind, there are many possibilities, but in the expert’s mind there are few. —Suzuki Shunryu

This Zen Master’s quote introduces us to the paradoxical nature of everything we have been taught. Quotes such as this succinctly provide us some of the wisest ideas to ponder. People’s narratives of their experiences in whatever context they may appear also offer us insights into their experiences—how they felt, how they were influenced, what it meant to them.

Today’s popular literature is often replete with first-person narratives. Because they are “real,” they hold readers in awe and provide them with pathways to understanding.

This book, Nursing Leadership for Patient-Centered Care, does just that. It offers the reader an opportunity to understand what is actually occurring in nursing leadership and management, as well as in nursing practice at the bedside.

Later in this prologue, I will discuss the philosophical perspective of phenomenology, which, in basic terms, attempts to understand the meaning of another person’s experience. To understand others, though, you need a beginner’s mind—a fun place to be, because of the many possibilities of understanding that open up to you. Some of these possibilities you might not have imagined before.

“The greatest obstacle to discovery is not ignorance but the illusion of knowledge.” This quote by Daniel J. Boorstin, a prize-winning author and former librarian of congress, illustrates the notion that, if we think we know something, we do not look for answers. I call this premature closure to understanding an experience to its fullest, richest depth. A song by Tom Petty and the Heartbreakers also illustrates this point: “You don’t know how it
feels to be me.” I start each phenomenology workshop with this song. The chorus, repeated often, conveys in great clarity what phenomenology as a perspective attempts to resolve.

You might find this CD, entitled *Wildflowers*, worth the investment. Then, you can play it over and over again, so that you can begin to realize, even at a visceral level, how little we understand, really understand others. Often we say to someone, “I don’t know why I did that or why I said that.” In other words, we also struggle to understand ourselves.

There are many ways to approach the project of human understanding. But if we have been taught one way, adapted one theory, accepted it, applied it to staff or to patients, and it failed to work, then what?

We have to remember that each person we encounter can help us discover what is best for him or for her—if we remain open to learning. The other person, not us, is the expert on him or herself. Often, as nurse leaders and managers, or in patient care, we try to fit the staff or patient into our theory, when actually *that other person* should provide direction for a particular and individualizing theory; that is, once we understand that individual’s interior (subjective) world.

Dr. Forman’s book is about gaining that understanding from first-person narratives or stories: what happened to them, how it was for them, what they felt like, how they experienced the event, and importantly, what we should know about various sectors of the health care arena in this regard. How nurses and patients perceive conditions and procedures provides direction for nurse leaders and managers.

**THIS IS THE HOW OF THIS BOOK**

This book shows those in nursing leadership and management how to understand what is occurring on the units and at the bedside by listening to the people involved: the patient, the patient’s family, the staff nurse, the nurse manager, physicians, or members of support services departments such as housekeepers and transporters, among others. They tell us what is going on through their own perceptions of various situations. This produces *authentic-based knowledge*. Evidence-based practice, of course, has its place. But caution, here, also has its place when implementing such practice within general protocols—which are developed for the “average” person who might not exist, in fact. Best is to get to know each person as a *unique individual*. You might remember that concept from your first nursing class.
Dr. Forman, in writing this book, reflects the narratives of many different individuals. As you read their stories, you realize the need to understand and know them from the perspective of their uniqueness. Nurse leaders and managers are asked to put aside preconceptions so they can discover the many areas that are begging for their expertise and intervention. The best place to start is always by listening to those who are living, or who have lived, through the experience.

Nurse leaders and managers have a high calling. They navigate a challenging workplace with limited resources, conflicts to solve, complaints to resolve, patient complications, and patient care errors to prevent or to correct. It is a calling that requires courage and direction. This book provides a pathway lit by the voices of patients and family members, of nurses and other personnel.

**ANOTHER HOW OF THIS BOOK: PHILOSOPHICAL CONCEPTUAL ANALYSIS**

We gain insight into what constitutes the best nursing management/leadership practice, in general, by talking about imperfect scenarios, along with good scenarios. This is a *philosophical* process of conceptual analysis (different from the one we use in nursing). In this process, we first ask the question: “What is good nursing management?” (Soltis, 1968). Then, according to this process, we identify two categories as exemplars. In one category, we note those characteristics of excellent nursing management using examples to illustrate each point. In the other category, we note the characteristics of imperfect nursing management. The idea is that, to know what is good, we must also and always look critically at what might be considered poor nursing management.

**UNDERSTANDING THE OTHER: THE THIRD EARP**

Think of all the misunderstandings you experience in just one day, and all the chaos this causes. For the patient, misunderstanding can generate frustration, powerlessness, miscommunication, feelings of isolation, or even oppression. The complications often include medical and nursing errors such as pressure injuries, contractures, infections, and even death.

How about misunderstanding among staff? Think about the disastrous implications from labeling and gossiping, criticism, poor coordination and
delivery of care, and arguments. Some of the worst outcomes may be work place mobbing (Duffy, 2009) or work place violence, whether psychological or physical.

What is critical, in order to understand another person, is to suspend our assumptions, presuppositions, and even our book knowledge. We need to listen with what has been called the “third ear.” This requires an open mind that embraces discovery and welcomes possibilities. To do this, we must temporarily set aside what we think or know and listen carefully.

Not only should the patient be heard with this “third ear,” but also everyone else on the health care team. The modeling of this listening and the teaching of “how” to listen with the third ear is part of being the outstanding nurse manager.

**HOLISTIC PRACTICE INVOLVES MORE THAN THE PATIENT**

This brings me to the people we encounter each day in the workplace—the nurse leaders and managers who often feel overwhelmed. Are we going to add the dimension of understanding the staff as a holistic group of individuals, from the housekeeper to the attending physician, to their already over-the-top responsibilities?

The answer is yes, because it will promote the concept that they all deserve equal treatment as human beings, because it is the just and ethical way to practice, and because it will lead to greater success in a leadership role. Rather than extra work, it will eliminate the fallout, as mentioned above, that comes from “not understanding” and from miscommunication.

Rather then making life more difficult for the nurse in a leadership role, the time spent in understanding others and their experiences will make life less stressful, more successful, and as an added benefit, more rewarding. Taking time to understand the context and contingencies of another person’s life in the moment individualizes that person’s uniqueness.

**LEAVE YOUR TROUBLES ON THE DOORSTEP**

This idea of not taking “stuff” to work is naïve. Once we are on a unit, we cannot leave behind emotionally laden issues such as a dying mother, a sick child, a home in foreclosure, or a failing marriage.

Practicing nursing management from this holistic perspective is guaranteed to improve workplace morale, camaraderie, and cooperation. It en-
sures better nursing care. These are the benefits of taking the time and interest to listen. In contrast (remember conceptual analysis), perhaps the nurse manager is humanistic toward patients, but not particularly with her staff. Until she abdicates her “knowing” position—the position of power, assumptions, and expectations without considering the context of the staff member’s life in the moment—she will unfortunately be practicing a very mechanistic form of management.

Often, the prescription for this type of nursing management comes from textbooks. These prescriptions may be formulaic, given without context or contingency considerations. They have their place in that they provide a framework. But that framework must then be individualized.

A few last thoughts which I think are critical: This cannot be faked. It must be authentic. Being a nurse leader or manager is a position of privilege as opposed to power. One of the best characteristics of a nurse leader/manager is being attuned to the staff’s lives, and to understand them as individuals. If you do not believe me, ask a staff nurse if she or he agrees. Ask the nurse aide.

Too often staff members feel dehumanized. Remember “horizontal violence” (Roberts, 1983), which Dr. Forman covers later in this book. Briefly, not being able to address others in power, the staff practices destructive behavior to one another. Nurse managers who listen to the narratives of their staff in demonstrable ways, and show they are actually paying attention, eliminate many of these energy-depleting scenarios.

NOW TO THE CRUX OF THE MATTER: UNDERSTANDING ANOTHER IN AN EXPERIENCE

Before beginning a more detailed analysis of understanding the other, whether staff member or patient, I hope I have convinced you that this is not “more to do,” “impractical,” or “too soft,” but actually the path to becoming a successful nurse leader/manager. Some of what I am about to present may be familiar to those who have taken research courses and, in particular, have learned about qualitative research. No worries, though, even if you have not studied this, because I am not going to present the approach from the research perspective. I will present it as a way that is exemplified in this book: how to listen, how to understand another, and how to identify with the experience of others. This will be essentially a description of the method Dr. Forman has used in this book—a page turner you will enjoy reading, and from which you will learn in a way you might find unfamiliar.
To discover what is necessary to understand the other, let us start with a quote from Thomas Henry Huxley, a nineteenth century English biologist. He said,

Sit down before the fact like a little child, and be prepared to give up every preconceived notion, following humbly wherever and to whatever abyss nature leads or you shall learn nothing.

To understand another and even yourself, it is essential to acknowledge your preconceptions, beliefs, intuitions, motives, biases, and knowledge base. Remain open to a whole new perception of another or yourself. This is also a critical component of the philosophical phenomenological perspective that I try to live by.

This is the guiding framework for this book.

THE PHENOMENOLOGICAL PERSPECTIVE: THE SUBJECTIVE STUDY OF EXPERIENCE

I am glad to say—since many of us have invested much of our professional lives in advancing this way of thinking—that many nurses have come to embrace it. Those who are hesitant comprise a more scientific, fact-seeking, quantitatively oriented group, and they are needed. This is not a conversion-seeking discussion. The phenomenological perspective is a philosophy that seeks to understand the meaning of experiences for other people. The goal is to understand how individuals are experiencing what they are confronting.

As nurses, we see people when they are at their most vulnerable, at risk, in fragile conditions. It is critical that we find out what is going on inside them. What is it that they are experiencing? Is it anxiety, powerlessness, loss of self, fear of dying, pain, hopelessness, loneliness, and all the myriad of unique responses people have to illness and their experience of illness? From these perceptions, we plan nursing care. This is based on understanding the patient and his or her needs. There are no textbooks or protocols that can predict how an individual will interpret his experience or reality. This is where we need to listen with the “third ear.” This is how the nurse leader/manager meets her responsibilities to both patients and staff.

As a nurse leader and manager who has the potential to create an environment of caring, compassion, and also the most excellent nursing care
delivered, the same dynamic applies. She or he needs to understand the experience of all the members of the health care team. What meanings are they giving to what they perceive and to what they actually experience? Are they afraid and feeling inadequate, stressed, dealing with personal trauma, and perhaps distracted, or overwhelmed? Are they angry about their working conditions? Are they feeling tension and competition among staff? Do they feel that the nurse manager has favorites, or conversely, do they feel appreciated and respected?

Can you see how responses to experiences can be different for each person, patient, or staff member? Considering the variety of these responses, think how impossible it would be to have a one-way-fits-all model, which as mentioned, can lead to miscommunication, misunderstanding, and medical and nursing errors.

This book attests to the variety of circumstances that can occur, how individuals respond, and how—too often—practice is jeopardized. Where did the perception start that being in a hospital is dangerous?

If nurse managers and staff turned their attention to the subjective worlds of staff and patients, we could hopefully turn that perception around. This is a task of no small consequence, I admit. However, if we were to learn more about what is perceived as alarming, as this book clearly articulates, then an essential new paradigm for care would emerge.

In the *New York Times* Science Section (12/7/09), there was an article stating a frightening fact—more than half of the patients in intensive care units have infections, and they are more than twice as likely to die in the units as those who are infection free. These patients are in intensive care units for life-threatening conditions, but they do not die from those conditions. They die from what we call iatrogenesis, hospital-acquired conditions. Since objective knowledge has its limits in solving this problem, perhaps we need to look at the subjective worlds of all concerned.

This article refers to mostly respiratory infections, and hand washing is mentioned. In her book, Dr. Forman refers to a case in which a patient in an ICU suffers a stage-V infected pressure ulcer while on one-on-one care in an ICU. His nurse attributes this to diarrhea.

The question arises: what is the subjective world, or the interior world experience of a staff member who perhaps “cuts corners” in a particular situation? Is a demoralized staff member more likely to do this? To find out, we need to examine and understand each person’s phenomenological perspective.
HOW DO WE PRACTICE (OR WRITE) FROM THE PHENOMENOLOGICAL PERSPECTIVE?

**Vignette Phenomenology—a Funny-Sounding Word**

While I was working on my doctoral dissertation concerning phenomenology, my son was in third grade. As with many children his age, he seemed to like funny-sounding words. Hearing me often repeat the word phenomenology, he readily picked up and used this “wordy” word. After listening to my explanation, he thought it meant to situate oneself in the place of the “other” to understand that other person. So in an essay he was writing on bullying, he inserted the word phenomenology as a way to combat bullying.

Of course this scored some points with his teacher, who called me to ask what the word phenomenology meant. Once I explained it to her, she agreed. Subsequently, she taught her students to imagine how it “feels” to be bullied—the sentiment expressed in the Tom Petty song. From a phenomenological perspective, though, we would go one step further and ask some children who had been bullied to describe the experience in their own words and the meanings they attached to these unfortunate experiences.

While you are reading this book, you are actually reading the phenomenological perspectives of nurse leaders, nurse managers, staff, family members, and patients. Therefore, you have examples of how revealing it is to hear people describe their experiences. These are rich narratives that will provide direction for practice.

You might ask, “Isn’t that the same as empathy?” Empathy is often described as putting oneself in others’ shoes and feeling as they feel.

We do that with phenomenology in a way, but instead—and this is a big INSTEAD—we do not assume that we know the pain and suffering of others—that our feelings are the same as are their feelings or that we perceive experience in a similar manner. Instead, we ask them to talk to us from their own experience. As mentioned previously, we honor their uniqueness and all the possibilities of their individual responses and feelings. We want to know how they are experiencing something but also what meaning it has for them. If we were to limit our understanding of others to our own perspectives, then we would be coming from our own interior world. It would be about us and our subjective stance toward the
world. It would rely on our own beliefs, values, perceptions, and knowledge—all the components mentioned earlier that need to be suspended when approaching an experience phenomenologically. We do not interpret the experience for another. We encourage the individual to have the freedom to interpret his or her own experience. This is what you will be doing when you read the narratives and stories told in this book. You will have the authentic account, not one you interpreted from your own life experiences.

*This is critical.* The sequence of events that opens this book and the one in the epilogue are examples of phenomenological narratives. They are first-person accounts with all the attendant feelings, responses, and meanings articulated from the persons who experienced the phenomenon.

So you can see where the term *phenomenology* comes from. Philosophy, like most disciplines, has its own vocabulary. Instead of simply calling a situation an experience, philosophers called it a phenomenon. Technically, with “ology” added, phenomenology is the study of phenomena. But it could just as easily be called the study of experience.

**THE ROAD TO UNDERSTANDING:**

**THE INTERSUBJECTIVENESS OF “WE-NESS”**

I hope that the argument for the importance of understanding the uniqueness of another, and her or his perception of an experience, has been understood. Recall that the way the nurse leader/manager can best perform her role is to understand the holistic nature of all who are in her environment. She needs to appreciate how people experience and attach meaning to being on the staff in order to produce the best results in the most humanistic, compassionate, and effective ways possible.

How patients and staff view their reality, what they are experiencing and feeling, what meaning they attach needs to be understood by all concerned. Everyone is intertwined. There is a “we-ness” of two subjective worlds coming together creating an intersubjective space where understanding becomes possible (further discussed in next section). By assuming a phenomenological perspective, the nurse leader/manager ensures that the staff and patient experience is understood; she provides compassion and understanding that is individualized for staff and patients alike. This improves patient outcomes and decreases complications and
errors. That it also makes the work experience gratifying is another one of its greatest rewards.

**AUTHENTIC LISTENING—HOW AND WHAT**

Now down to the “how” of authentic listening, in order to understand, without “the illusion of knowledge.” Let me explain how I am using the word “perception” for the purposes of this prologue and also how it is structured as the framework for this book. First a question: which comes first—subjectivity or perception? The answer is that both are essential to the existence of the other. They are simultaneous in nature. But first, one must perceive.

**Perception**

Perception is largely how we *individually* view the world and all its parts and regarding this book, how we view the role of the nurse leader/manager and the all-inclusive staff.

Throughout the course of our own personal development, we appropriate various beliefs, values, intuitions, preconceptions, assumptions, book knowledge, and inherited knowledge from others. This includes biases and everything else that adds up to our worldview, from the topic of this book to the color blue. Perceptions that are built on prejudices and partiality (addressed in this book) can be extremely harmful. When we attempt to understand another individual, everything that contributes to our perceptions—especially prejudices and predispositions—should all be held in abeyance. That is, to the extent possible for us, we must disregard and place aside anything that has contributed to our own perception of something. This step is absolutely essential to obtain a true understanding of another person.

It is in the common parlance that our perceptions create our own reality. We all have different perceptions of the same reality. This is a cause for conflict and disagreements as we are often talking right past a person. A self-help book that you might have read demonstrates this vividly. It is John Gray’s, *Men are from Mars, Women are from Venus* (1992). This book illustrates in a fun and informative way why men and women are so often in conflict. Each sees reality from what Gray tells us is from two completely different sets of perceptions. If you have not read the book, I strongly recommend it to improve your relationships with the opposite sex—in both the personal and professional realm.
In addition, “what WE would do” in that person’s situation, also must be placed aside. What might be good for one person may be inappropriate or even disastrous for another.

So, in phenomenological understanding, the knower is the person whom we are trying to understand. We should not question the validity of the knower. Whatever that person reports is that person’s perception. Whether we agree or disagree, our aim is to understand how that individual is viewing an experience. Our opinion should not be running along parallel to the person talking to us.

I have used the following technique and admit it takes practice. Simply, I keep my mouth shut or use words to encourage the person to continue. I have heard and probably have been guilty as well of statements like, “but don’t you think” or, “that is not really what is happening.” But you can see how that would interfere with understanding the authentic telling of the person’s experience. So when you read Dr. Forman’s book, you might hear yourself saying, “but that could not be helped” or “that is exaggerated”. I urge you to suspend interjecting your own perceptions at the moment of reading. Let each example in this book have his or her own voice, his or her own telling of the experience, his or her own perceptions of the event.

**Intersubjectivity**

Each of us has our own subjective worldview, our own window to interpreting the world and all that it holds. Residing in our subjective world, or the subjective part of our consciousness, are our perceptions. The other part of our consciousness is sometimes referred to as an objective world. We might interpret that objectivity as agreed upon facts.

Philosophers have argued about objectivity, or lack of it, for eons. Objective facts are supposedly immutable—unchangeable—so we do not have to argue about them like we might about our subjective world. But we all have an idea as to how many so-called objective facts have not held up through time. So it is a good idea to be cautious with “facts.”

We are sometimes told to be objective or to give an objective opinion. From my perspective, these two ideas are going to wind up being subjective. I recall hearing at a conference once, that objectivity is a subjective notion. That works for me, but not for everyone. Also, it is another chapter for another book!

We are speaking about intersubjectivity. What this means is when two or more people come together, there is a melding of the different subjectivities.
Therefore, when we are conversing, each person speaks from her or his own subjective world with individual respective perceptions. An intersubjective space then opens up with this mergence of two subjectivities. In this space, as mentioned, filled with individual perceptions, conflicts, disagreements, and agreements take place. So it is a place worthy of our critical attention.

**WHAT MAKES IT PHENOMENOLOGICAL IS TO OBTAIN UNDERSTANDING OF THE OTHER**

Now that we have arrived at this point, I once again encourage you to read Dr. Forman's book from this phenomenological perspective, especially since it was written that way.

**GIVE VOICE TO ANOTHER WITHOUT YOUR OWN OVERLAP**

This means, in this instance and with individuals you are attempting to understand, that you acknowledge your subjective consciousness. Hold your perceptions in abeyance. Place your subjectivity on the shelf and listen without the noise of self—listen with your third ear.

This is the phenomenological idea of the use of intersubjectivity in the pursuit of understanding the experience of another and for understanding that experience. As to the intersubjective space: you remove your own subjective stance and allow the other to eclipse yours. Then, you will be able to hear how that person actually experiences a phenomenon in the most authentic way.

**IN THIS BOOK AND IN YOUR EXPERIENCE**

An excellent place to start “listening” with your third ear is right here, with this book. Some of you may object to depictions of experiences by the narrator, patients, or staff. That is your subjective response. However, if you were to listen in an intersubjective way, you would suspend your subjective response and read the narrative or example as presented—it is a true telling of an experience from another person’s subjective world. That world as told in the narrative is authentic for that person. Hearing it and accepting it, even if at first it might offend, offers great opportunity for professional and personal growth.
WANTED: NURSE MANAGERS WHO LISTEN WITH THE THIRD EAR

We need excellent nurse leaders, managers, and nurses who are able to listen with the third ear to staff, patients, and families. They should be in a holistic environment where they feel welcomed to talk without prejudice or fear; where they welcome the other’s subjective experience, where they are completely respectful of other’s subjective world. The nurse leader/manager realizes this is the person’s authentic perception of the experience. This nurse leader/manager is rewarded by a rich and satisfying practice.

Listening to another person’s interpretation of their experiences—and responding with thoughtfulness, respect, kindness, compassion, generosity, caring, and authenticity—is the path to individualized leadership and management practice, as well as excellent nursing care. Using the phenomenological perspective to listen keeps the noise out, so that staff and patient voices are heard with clarity like the ring of fine crystal. The nurse leader/manager has a special calling; she is a unique individual who can create change so that another book like this may not be needed. That is my desire for all nurse managers, nurses, auxiliary staff, patients, and their families. Utopian thinking? Perhaps, but it gives us all a goal.

In her epilogue, Dr. Forman refers to a quote from the Kaballah about the end being in its beginning. I would like to follow suit. Since I began with a quote about possibilities, I would like to end with one as well, one that illustrates what nurses need to acknowledge about all those individuals in their environment, including themselves. This one is from Peter Senge who said, “We need to be the authors of our own life.”

CHAPTER ENDNOTES


The Three Cs: Collaboration, Communication, and Cooperation

Coming together is a beginning. Keeping together is progress. Working together is success. — Henry Ford

NURSE/PATIENT COLLABORATION, COMMUNICATION, AND COOPERATION

Vignette Setting the Stage With a Merkel Cell Carcinoma

A Merkel cell carcinoma—a rare aggressive type of skin cancer—had been surgically excised from the patient’s upper thigh by a well-reputed surgeon in a renowned medical center. Ten days later, as the sutures were being removed, the wound dehisced and bled profusely. The surgeon packed the wound, which measured 15×8 cm, and was 5 cm deep, and released the patient with a referral to a home nursing service.

The next morning, a nurse arrived, assessed the wound, and told the patient that he needed to be in the hospital. She then contacted the surgeon to make the necessary arrangements.

The patient and his wife packed a bag and headed for the admissions department to complete the paperwork. The clerk directed them to the specified floor and unit.

By the time they arrived, the patient was exhausted, and they could not find his room. There were no clear signs, and no one was in sight to ask. Finally, they located the room—a double with two unmade beds. Linen was piled on an air exchange unit. Neither bed was occupied nor had they any idea to which bed he had been assigned. They claimed the bed near the window and the wife settled her husband into a chair. She pressed the nurse call button. No one responded.

After 10 minutes, the wife made the bed and helped her husband to lie down. She noticed blood soaking through his trousers.
Alarmed, she located a nurse and told her about it. The nurse said she could do nothing without a doctor’s orders and walked away.

The patient’s wife rifled through drawers and closets until she found gauze and tape with which she reinforced the dressing. Then she went to the desk and found a resident physician who said he could come in 7 minutes, but not immediately.

This was the beginning of a week of care that was anything but patient-centered. That is what this book is about: patient-centered care that is all too often lacking in today’s beleaguered health care system. It is also about health care professionals and support staff who appear exhausted, have unclear missions and goals, and seem to suffer from ambiguous leadership and uncertain management. They are battling a myriad of these and other self-defeating issues that thwart even the most motivated professionals.

The nurse, in the above scenario, was wrong when she said she needed a doctor’s order to treat the bleeding wound. Her responsibility at the time was to that patient. In a patient-centered environment, she would have known that. This is the very definition of nursing under the American Nurses Association’s (ANA) Social Policy Statement. In fact, her hospital had achieved Magnet Status (ANA: Nursing Administration Scope & Standards of Practice, 2009)—and had she understood what that meant, she would have known that her organization was expected to deliver excellent patient outcomes.

Had the nurse studied Nightingale or Henderson, founders of modern nursing, she would have known that the nurse is responsible for doing for the patient that which the patient would do for himself—had he the capacity to do so. Sadly, by her actions, she seemed to be unaware of any of these things—only that she could turn her back and walk away.

During the entire week of hospitalization, not one nurse discussed the patient’s diagnosis or possible outcomes with him. They gave him his meds and dressed his wound per MD’s orders. They attended to the tasks.

He had a grievous wound and was seen by a dietician who recommended a high-protein diet. She advised his wife to bring at least one such meal each day from home because it was unlikely that the hospital meals would meet his protein needs.

Because there was a contaminant in the water system, he could not use the bathroom shower or sink. No one offered to assist him with the packaged bed bath that was supplied to him with the linen. He had to ask.
Here is another story of lack of cooperation, collaboration, and communication between a patient and members of a nursing service that resulted in unacceptable care. In this case, the patient signed herself out of a hospital against medical advice (AMA), thus jeopardizing her health and ultimately the hospital’s malpractice standing.

**Vignette From the Mouth of the Patient**

Having had several bouts of viral meningitis, when I had familiar symptoms I went to the emergency room of my hospital. By the time I got there I was in excruciating pain. The ER was packed. I was put on a stretcher and left in the hallway among other patients for nearly ten hours covered only with my jacket. Finally, a staff member rolled my stretcher into an isolation room. There I was told by a nurse that there were no blankets or pillows available. There was neither a bathroom in the isolation room nor a commode. After several unattended hours I needed to void and called out for help. No one responded. I got off the stretcher. Weak and in excruciating pain I stood at the door and called out. Still no one responded. I walked out of the isolation room and fainted.

Just then, the patient’s parents arrived and as they later described it, they were shaken by the flurry of activity surrounding their daughter. They later learned that she had not been given even a sheet or blanket despite the well-stocked linen carts they had seen near the ER entrance. Also, they were distressed to learn that a bedside commode had not been supplied, that the many calls to the staff had been ignored, and that their daughter’s pain had not been addressed. There had been no collaboration between the nursing staff and this patient who had been left without essential care for many hours.

This too, was a Magnet Hospital. Nevertheless, nursing was unavailable to this patient, and according to the parents, to the many patients who lay on stretchers in the corridor separating the glass-enclosed centralized nursing station from the examining rooms. Each patient’s privacy was minimally protected by a portable screen. Instead of sheets or blankets, they were covered only by their coats and jackets.

Eventually, this patient was transferred, first to a temporary room assignment to clear ER space and then to her room. As the patient continues:
I was there for less than an hour when an orderly entered the room with a wheelchair to transfer me to another room. I told him that I would need a gurney since I could not sit up. He came back with one and told me to get on it. I told him I needed assistance—a step stool or something. He got one but offered no help. As he was wheeling me out of the room he coughed without covering his nose and mouth. Several days later—because of lack of attention and poor care—I decided to check out AMA. The night before discharge, I called the nurse and told her that I was very cold and was shivering uncontrollably. She told me I was having an anxiety attack about going home the next day, and that I should sleep. I awoke in the middle of the night feeling as if my lungs and throat were on fire. I pressed the call button for about 10 minutes, but nobody responded. Finally I went to the main desk and demanded that someone take my temperature. They begrudgingly complied until they saw that my temperature was 106°F. They packed me in ice and gave me Tylenol. I left the next morning—against medical advice—believing myself in danger due to poor care.

Discussion: The parents wrote to the chief nurse executive (CNE) and received a pro forma response. As you read this and the other vignettes in this chapter, think about how these situations might have been better handled, bearing in mind that short staffing is a reality in health care today and is likely to worsen. Also, consider that most of the hospitals I am discussing have well-educated individuals at the helm—at least masters prepared. At the upper leadership levels, some have earned doctorates. All facilities are Joint Commission accredited and many have been awarded Magnet Status. The vignettes described here, reported by patients, their significant others, and the author and other professionals including nurses, physicians, and therapists among others, should be carefully considered. Questions about what went wrong and what could have been done to offer better, more professional, more satisfying care, need to be answered.

STAFF: MANAGEMENT/LEADERSHIP COLLABORATION, COMMUNICATION, COOPERATION

The previous story was from the patient’s perspective and took place in suburban New York. Here is another story about lack of collaboration, communication, and cooperation, this time between staff and leadership. It
happened in a large voluntary hospital in the south where staff members felt they were not valued by management.

The CEO of a 570-bed acute care hospital conducted monthly staff meetings in the auditorium. All available staff members, from the groundskeepers to the administrators, were invited to attend and “speak their minds.” Many took part even though, based on past history, follow-through seemed unlikely. One day, a staff RN, known to share his views freely, was about to enter the auditorium. His supervisor, with a snide smile on her face approached him and lifted his ID badge. “Remember,” she said “I know who you are.” The RN took this to mean “keep your mouth shut!”

Soon after the meeting ended, word of this incident spread like wildfire. The supervisor said she had just been kidding. Had her staff trusted her, they might have believed her. But based on her past behavior, which was punitive and authoritarian, that was not the case; therefore, it was too late to stop the negative cascade that her words started.

Groups of staff members gathered in corners and discussed the event. Like the children’s game of telephone, with each repetition, the version changed. Instead of the supervisor having said, “I know who you are,” by the end of the week, the message became, “if you open your mouth and say one word, I’ll fire you.”

Nothing management could say or do seemed able to put out the rapidly spreading conflagration. Confidence was low. Communication flowed in one direction: from top down. Managers had not established one-on-one relationships with individual staff members, so there was little or no communication from the bottom up. Also, patient-focused language was not the norm. Me’s, you’s, and we’s were standard, and this caused competition instead of cooperation. Staff members talked about contacting unions to represent them against management. Things were going from bad to worse.

Finally, the CNE called in a consultant to see what he could do to break the stalemate that had hardened the staff. He asked for a meeting with the most outspoken, angry, and obdurate nurses to see if they would participate in a focus group. Many stepped forward; 20 were chosen by lottery.

At the start of the meeting, he announced that they were welcome to contribute anonymously. To a person, they declined to remove their ID badges. Attendance was not taken.

It was an open forum. The nurses painted a picture of poor leadership and management. Examples started with the monthly CEO meetings, after which there was seldom any follow-up. The CEO’s agenda was task and
physical plant, not staff or patient oriented. He listened, but that is where it ended. He neither promised nor provided solutions to the problems the staff articulated. This in itself was demotivating.

Supervisors, like the one who started the problem, were archetypal. Managers did not work at establishing relationships with staff members; they were mostly absent from their units, and when they were there, they clung to their clipboards and rarely lent a hand. They tended to be authoritative, punitive, and demanding. Instead of supporting staff, they placed blame—often in front of patients and others. Also, they played favorites, ensuring that their friends received preferential scheduling, performance appraisals, and promotions.

By the time the meeting’s allotted hour ended, the consultant had six legal-size pages of notes—grievances actually—against management. They asked the consultant what he intended to do. He replied that he would report back to the CNE who had invited him in with his recommendations for an action plan that would include periodic meetings with this same group to review their perception of progress.

The CNE, who was relatively new to the organization, practiced MBWA. She was a warm person who was humanistic by nature, and expressed concern for both patients and staff. Regular three-shift rounds and around-the-clock staff meetings were routine for her, and she arranged with the consultant to conduct professional management seminars and leadership workshops. Next, she arranged for substandard managers to be counseled, participate in remediation, and if unable to rise to new standards, let go and replaced.

As promised, the consultant met regularly with the original group that had become the steering committee and the voice of the staff. They reported an improvement in morale, which took a bounce when the punitive supervisor—the one who started the furor in the first place—was replaced with a patient- and staff-oriented professional manager.

The staff noticed steady improvements in communication, leadership skills, management visibility, and interaction on the units. Monthly administrative meetings continued, and there was follow-up on issues raised. Staff members were beginning to believe that management cared about them as individuals and hope started to replace anger. They now could turn their attention to their patients. The new formula in which management cares for staff, in turn, motivating staff to care for patients, was starting to take root.

On a return visit—one to gauge leadership style and effectiveness—the consultant asked the steering committee about leadership styles.

He wanted to know if staff members:
Felt safe to disagree without fear of reprisal.
Were included in decision making.
Were not spoken down to or felt demeaned.
Were praised publically and criticized privately.
Had opportunities for promotion based on demonstrated expertise.
Had opportunities to present new ideas that would improve patient outcome and ease their workload.
Believed they were working with patient-centered leaders who demonstrated positive behavioral styles and communicated effectively.
Cooperated and collaborated in a way that had a positive impact on patient care.
Felt good working in that leadership environment and believed patients felt good about the care they received.
Experienced their managers as good role models and mentors.

The consensus opinion was that there was discernible improvement but that insufficient time had transpired for trust to have replaced the former levels of doubt. The phrase “time will tell” seemed to be their position.

At this point, a word or two about the concepts of demonstrated expertise versus years of experience used as a parameter for employment and advancement. I have observed individuals with decades of work experience whose skill sets did not compare favorably to relative neophytes who aced everything they took on. Yet I continue to see—in recruitment ads and ads for management and leadership advancement—a requirement for “at least five years of experience.” Also, there is a tendency in nursing to be narrow-minded about educational requirements for leadership and academic positions. While in many other professions the doctorate rules, in nursing, even for nonclinical positions, the master’s degree often trumps the doctorate. Employers frequently miss opportunities to mentor neophyte nurses and enhance patient-centered care. I encourage readers to rethink their own experience and how it translates to on-the-job expertise. The future rests with you. Holding on to old habits and tired practice ensures a continuation of old paradigms.

**NURSING TEAM MEMBERS’ COLLABORATION, COMMUNICATION, COOPERATION**

The patient was comatose—obtunded. He also was overweight and required several sets of staff member’s hands to reposition him. With proper body
mechanics, two or three experienced nursing personnel could do it. Some insisted on a fourth.

Often, RNs entered the room and asked the family members where the NAs were. The family could always locate an aide or two, or more. The question was: why could the nurses not do so as well?

Upon investigation, it was learned that many of the nurses talked down to the NAs, and in so doing, diminished their worth, angered them, and made them want to get even. So they did, by making themselves unavailable to help out when needed. The conflict trickled down to the patients and resulted in a work environment that was not patient-centered. Support staff was uncooperative. Patients had to wait for care. This annoyed the RNs, and a vicious cycle was established.

The family members, on the other hand, valued the input of the NAs and showed their appreciation. All it took was a please, a thank you, and a how ya’ doing?

There were other examples of RN misbehavior. For example, a medical student requested help from a nurse because he was having trouble drawing blood from a central line. Instead of offering immediate assistance, she made him wait. She had “other obligations,” she said. These turned out to be powdering her nose, making a personal phone call, having a tête-à-tête with a colleague, and applying lipstick. Then, she returned to the bedside and assisted the beleaguered med student.

This patient’s length of stay (LOS) was approximately 28 days, a long time in an acute care hospital. Although there was a nurse manager’s office on the unit, the nurse manager never visited the patient. To make matters worse, there was a different primary nurse each day. When the family asked why, they were told that every nurse wanted to get to know every patient. This author has heard from a number of family members that “primary nurses” were changed daily during inpatient stays in a number of acute care hospitals in several large metropolitan areas. Although these individuals knew nothing about the theoretical framework behind primary nursing, they reported feeling disconcerted by frequent changes in staff.

In a third example from the same unit, the patient was returning from the OR on a special bed. The room he was assigned had a bed in it. The mother advised the unit clerk and suggested that the bed be removed so that her son need not wait in the hall. Several orderlies were standing by and could easily have handled it.

That would have been patient-centered behavior. Instead, the clerk, never looking up from her paper work, mumbled: “The transporters will take care of it.”
Who Is at the Center of Attention in Patient-Centered Care?

There is no question that the patient’s and his family’s needs should have been the center of attention—not the nurses. But where was the nurse manager to oversee, mentor, and evaluate her staff in this philosophy? The family asked if she was off duty, but she was not. The nurses identified themselves as primary nurses, yet they ignored the philosophy of primary nursing.

To make matters worse, there were several patient care breakdowns. A Foley catheter was found by a family member to have been left clamped; the urine that had accumulated in the collection bag was scant and concentrated; an IV had “run out,” and an air mattress had deflated. The nurses became defensive when informed.

Here are some questions to ponder when thinking about how these stories apply to your own practice:

- How would you have gone about shifting from these staff-centered philosophies and practices to patient-centered care?
- How would you find out if fear of reprisal was pervasive among patients and/or family members who complained about lack of consistency or nursing care breakdowns on this unit?
- What would you do about adversarial relationships between NAs and RNs?
- Define the steps you would take and the management/leadership support you would need.

This vignette speaks to the problem of patient care breakdowns and support staff not cooperating with professional licensed nurses. It spotlights the consequences of changing primary nurses daily because “they all want to get to know” patients on their unit. But this is clearly not patient-centered behavior.

What steps, if any, should the family have taken? In this case, the family provided care with some support from staff. Families and patients are often loathe to complain for fear of reprisal or “of making it worse.” This is especially disturbing in cases where NAs roughly handle frail elderly patients. Adult children are often afraid to “make waves.” Sometimes even racial or religious conflict is brought up as a concern.

One solution is for the nurse manager to be out and about on the units, among patients and staff. It does not take long for a skilled eye to see rough treatment or the results of rough treatment. Unfortunately, two things often interfere with taking action. One is short staffing, and the other is fear of retaliation or fear of a union. Neither of these are excuses.
Nursing Leadership for Patient-Centered Care

Ask yourself these questions, and be painfully honest:

- How would you feel as a NA on that unit? Those NAs were angry and wanted to get back at the RNs. But disempowered, they simply made themselves unavailable.
- Do you consider support staff equal to you in all things other than professional licensure and all responsibilities that flow from that?
- Now, consider how and if you greet and treat your support team members—including the housekeeper who mops the floor.
- Given the opportunity, how would you go about shifting from egocentric behaviors to staff-centered/patient-centered care?

Here is a suggestion: start by asking patients how it feels to be cared for on your unit. Then do the same with your support staff. When you meet with them, really listen. Walk a mile in their shoes. Be empathetic. Feel their pain. Remember, empathy does not take time. It is an attitude, not a task.

One of the things that motivated me to write this book was a conversation I overheard on a New York City bus between two elderly women. One said to the other:

“I never want to have that experience again.”
“What experience?” asked her companion.
“Having to be a patient in a hospital,” answered the first woman.
“What happened?” queried the friend.
“I never felt so neglected, so vulnerable, so alone and uncared for in my life.” the former patient said.
“My goodness,” said her friend. “Where were you?”

The hospital named was a major, well-known medical center, Joint Commission accredited, affiliated with a medical school, and honored with Magnet Status. Still, the two elderly patients on that bus did not think much of its nursing care.

I went home and started to write a proposal to my publisher. For years, I had been thinking about writing a book of this kind and had been collecting vignettes. The one on the bus was my tipping point.

**ROLES OF MANAGEMENT**

An important role of management is to evaluate and improve staff effectiveness within and among the various disciplines. MBWA provides simultaneous observation of staff demeanor and behavior, staff interaction, and patient care intervention and outcomes. It also affords the manager op-
portunities to interact with patients and physicians, and to work alongside staff and mentor them in their clinical, observational, and communication skills.

In order for this to be effective, high levels of trust among and between staff and management must exist and endure. In the following vignette, trust was eroded. What follows is an account of revelation, evaluation, deconstruction, and reconstruction of an interdisciplinary team.

INTERDISCIPLINARY TEAM COLLABORATION, COMMUNICATION, AND COOPERATION

She was a consultant in a 300-bed suburban medical center that was part of a large horizontal health care system. Her charge was to work with middle management nursing staff to improve their leadership, management, and communication skills. Team building within the nursing department was to be closely followed by interdisciplinary cooperation and collaboration and improved labor relations. The ultimate goal was patient-centered care excellence.

One day, while making rounds on a medical unit, a patient coded, and a medication was needed—stat! The unit clerk called pharmacy for the drug and said: “I need drug _____ STAT! for patient so-and-so in bed . . .” Pharmacy responded that they were busy and had no one to deliver the drug.

The unit clerk frantically replied that there was no one free to run to pharmacy, and an argument ensued. The consultant herself rushed to pharmacy and told them that a patient had coded and needed the drug. A pharmacy tech ran the drug to the unit. The consultant stayed and met with the pharmacy staff and the director who said that if the clerk had explained that a “coded patient” needed the drug, he himself would have delivered it.

This is an excellent example of the difference patient-centered communication would have made had it been the norm of the institution. Instead, efficiency fell victim to egocentric communication and a lack of teamwork. The result was poor patient outcome, substandard management and leadership, and self-centered care. These were problems the consultant had been called in to resolve.

Self-centered or departmental-centered communication—the I’s have it—is typical and is often the root cause of intra- and interdepartmental rivalry. A simple shift to “the patient,” or better yet, “our patient” terminology would help eliminate that rivalry and improve cooperation. But making the
shift is not so simple because we human beings tend to think of ourselves first. For example, we often start by saying, “I need. . . .” We often leave out the specifics of what we need and why we need it. In the above stated case, the unit clerk neglected to say the patient had coded.

Discussion and Application to Practice

In this vignette, misunderstanding between two essential departments—nursing and pharmacy—could have endangered a patient. Simply replacing the word I with the words the patient would likely have changed the paradigm. Think about the following questions and suggestions:

- Start counting the numbers of times you use the word “I” in a sentence—spoken and written.
- Practice substituting the word patient or we for I.
- Have you ever tried to think of yourself as “the other guy?” Imagine trading places with the patient, a support staff member, or an interdisciplinary team member.
- What steps might you take to shift to patient-centered thinking? Be specific.
- How about patient-centered communication? What might you do to define it and adopt it?
- Again, be candid: do you consider nursing and nurses to be more important than other services? Include in your consideration pharmacists, physical and occupational therapists, social workers, radiation techs, physician assistants, lab techs, and other professionals and paraprofessionals.
- Do you think nursing gets the respect it deserves?
- Do you get the respect you deserve?

NURSE/PHYSICIAN COLLABORATION, COMMUNICATION, COOPERATION

A master’s prepared Caucasian advanced practice nurse (APN)—with expertise in coronary care—came upon two Asian PGY-1 resident physicians executing CPR on a hospital visitor who had suffered cardiac arrest. Noting that the MD applying chest compressions had his hands placed several centimeters below the sternum, she knelt beside them and quietly repositioned his hands. The code was a success, and the patient was transferred into the Coronary Care Unit (CCU) with the APN and the two MDs in attendance.
After everything settled down, the physicians severely chastised the nurse for “daring” to correct them publicly. She was extremely upset and went to see her CNE to describe what happened. The CNE called the chief of medical affairs (COM) and arranged an immediate conference. The COM listened carefully and paged the doctors, asking them to come to the CNE’s office where they defended their behavior. They boldly stated that the nurse was not responsible for patient outcome—they were. They said she had made them “lose face” by correcting them publicly.

Cultural differences both simplified and complicated this situation. The relatively easy part was a show and tell—showing them the state’s Nurse Practice Act. From this, it was clear that the APN was accountable for patient outcome as long as she had the knowledge to diagnose and treat actual and potential health care problems. In this case, the resultant health care problem would likely have been death.

The cultural element was trickier. Obviously, they knew they were in the United States, a country that at least theoretically puts women on an equal footing with men. Nevertheless, there are many men from certain cultures and countries living here who may not understand or accept this. As a result, the CNE and COM stuck to discussing behavior. Simply stated, the PGY-1’s behavior was unacceptable and would not be tolerated. The two physicians may have lost face, but the confrontation ended without hard feelings. One reason is that the APN had not demanded a public apology. She accepted their apology in the relative privacy of the CNE’s office before the meeting ended in order to re-establish patient-centered collegiality.

Among other lessons, this vignette points out how important it is to be able to refer to the nurse practice act of your state. In Chapter 10, we will analyze the legal definitions of nursing as well as what nurses say when asked what they do. Nursing is a fine art based on science. It is an important profession, one that is needed everywhere and by everyone at one time or another. Yet, many patients, and sadly many nurses, cannot define what it is nurses actually do. This advanced practice nurse, by her actions, defined nursing well—and was chastised for it. Her director and the chief of medicine backed her. By their actions, two PGY-1 resident physicians were afforded an unusual learning opportunity.

Do you think ignorance of the nurse’s role is widespread among physicians, as well as among other health care professionals? What about among nurses, administrators, patients, legislators, and consumers? If you do believe ignorance is widespread, what have you done about it? What do you think should be done about it?
The encounter reported in the previous vignette was an unusual one. Yet nurses and doctors regularly work together in tight knit clusters. Is there mutual respect? Is there tolerance? Is there disdain? Deference? Admiration? How about all of the foregoing? Or, as my economics professor used to say—*It depends*. With some physicians, it does not matter how skilled a nurse is. To them, no one meets the lofty level of a physician except another physician. No one, that is, until a really good nurse pulls that doctor’s feet from the fire.

**Discussion and Questions to Ponder As You Think About Application to Practice**

- Are there circumstances under which you would or would not correct physicians, even if you knew they were wrong? If not, why not?
- What might you have said or done if MDs chastised you the way they reprimanded the APN?
- Do you know the legal definition of nursing for your state? If not, learn it. The ANA Social Policy Statement Appears in Chapter 10 of this book. Use it as a reference. Check out the Scope of Nursing Practice at your place of employment. Know your rights and responsibilities under the law. Practice nursing as a profession, not as a trade. Be proud of what you do.
- Do you believe you would have been supported by your administration, as the APN was in this example?

**NURSING/FAMILY MEMBER COLLABORATION, COMMUNICATION, COOPERATION**

A 65-year-old man who had recently undergone a quintuple bypass awakened at home with chest pain. His wife, legally blind, called 911 and then contacted her sister—an RN—and asked her to meet them at a local hospital. They met at the ER and expected that they would be permitted to stay with the patient—now extremely agitated—throughout the assessment process. They were wrong. The rules got in the way. Patients over the age of 65 were to be assessed without family intervention, even if the patient requested it. The RN asked for professional courtesy, explaining that the patient could not give an adequate history on his own. He depended on his wife to do so, and she, due to her blindness, depended on her RN sister to join them at the hospital and help them maneuver through the red tape.
The more she talked, the more officious the supervisor became. She finally called over a large security guard who was a moonlighting county police officer. He quoted the rules and forced the RN out of the unit. But she managed to call out to her brother-in-law, instructing him to ask the doctor to allow his wife and sister-in-law to return.

That is what he did. The same supervisor who had them ejected had them readmitted a short time later. The RN asked her if she was embarrassed. She denied that and insisted she was just “following the rules.”

Think about rules that:

- Constrain you in your place of employment.
- Constrain your patients.
- Constrain their visitors.

Do you ever make exceptions to these rules? If not, why not?

I saw a bit on TV the other day. A sign over an ICU stated: “No visitors under the age of fifteen.”

A mother appeared with her 11-year-old son. She asked to gain admittance. An argument ensued. The ICU nurse said the rules were clear. The mother said the boy wanted to say goodbye to his dying father. “Nevertheless, he is under 15,” said the nurse. “But,” said the mother, “the boy wants to see his father for the last time. He will not make a scene.”

What would you have done?

Many ICUs have rules that allow visiting in 15-minute intervals every several hours. What if your loved one was terminally ill and actively dying? Would you not want the rules stretched so you could be there at his final breath? Some nurses allow for that. Some do not. For them, rules prevail.

Some parents climb into the crib of a dying child. Some nurses want them to climb out. Rules or broken hearts—which are more important? Reading this book, you know my answer. But would you still feel that way if you were on a busy unit? Remember, empathy is an attitude that takes no additional time.

NURSING/VENDOR COLLABORATION, COMMUNICATION, COOPERATION

Not all hospital stories reflect negative experiences. For a change of pace, here is a positive one.

Shortly after taking over a nursing service, a CNE met with all levels of staff. It was the first time in the history of the institution—a hospital/nursing
home combination—that professional licensed personnel and unlicensed assistive and entry level personnel were invited to the same meeting.

The CNE introduced herself as an existential manager, one whose philosophy was to be both staff- and patient-centered. Then she asked if there was anything anyone wanted that would make their work life easier. After a moment or two of hushed disbelief a NA raised her hand. Once called upon, she explained that when visiting a friend who was a patient in a nearby hospital, she noticed an aide using a shampoo tray while washing a patient's hair. She said such a tray would be very useful for chronic respiratory patients and others too ill to be showered.

The CNE promised a response to this request within a week.

The next day, she personally called a vendor with whom she had a long-standing professional relationship. He checked with his supplier and delivered a dozen such trays the following day. The CNE asked the nurse managers to hand deliver the trays to those units that needed them. Finally, she personally contacted the NA who had requested them to thank her for her input.

Each tray cost $16.95.

This episode generated the first meeting of the newly formed Product Evaluation Committee. Philosophically, the CNE believed in power to the people. One way of imparting power was giving them decision-making ability over things they used in their everyday work. So she collaborated with the director of materials management to establish a committee to evaluate products for various factors. These included effectiveness, price control, aesthetics, and usefulness, among other things. Everything from washcloths and underpads to syringes and higher tech equipment went on the product evaluation list. Formation of the committee was congruent with the products to be evaluated. Refreshments were served, and participation was valued. Over time, expenditures went down, and a sense of control and importance went up. It became a win–win situation for all concerned. The new CNE had hit a bases loaded home run.

I have found that the quickest way to break the ice with a new group is to provide something good to eat and get them something they need or even perceive they need. The CNE in the above vignette, by quickly responding to this easy-to-accommodate request—shampoo trays—offered concrete proof that she took seriously both her staff's concerns and her patients' well-being. By asking the nurse managers to bring the trays to the units, she included them as a part of the staff-centered management team. Now the hard work was to begin. Think about what would have happened if she did not follow up as she said she would. Also consider the disappointment and resulting anger if this was a “one shot deal.”
Discussion and Points to Ponder as You Think About Application to Practice

Let us take on the entire organization as a point of discussion. Having a new CNE is an enormous change. It can be very threatening. It shakes the foundation of what is and has been the bedrock of daily life for an entire workgroup and, by extension, a workforce and a population of current and future patients. Now there is a new boss, and rumors have been flying. Human nature being what it is, the negatives have outweighed the positives. People are edgy. Although the workers feel safe because they are “protected” by union membership, change is always threatening. Nonunion employees are protected only by their history and perceived value to the organization. Everyone likes the status quo. They know what to expect, so there is perceived safety. But now, there is someone new at the helm, and the deck is bound to be shuffled.

The new leader is also facing some pretty intense challenges. She has been hired to correct many deficiencies, and she does not have a lot of time in which to do so. First, she has to win over her staff. Being a practical-minded person, she knows the staff has been rudderless and that previous leadership, as well as some of the remaining supervisors, have been authoritative and punitive. There has been little input encouraged from staff, especially lower echelon staff, and systems have been practically nonexistent.

The first thing she wants to do is send the message that she considers them equal as human beings. That was the reason for the inclusive meeting. She then wants to give them a voice and provide trust. So she asks them what they need and then gets it for them—shampoo trays.

She also asks them to be empathetic and existential—to walk a mile in the shoes of their housekeeping colleagues in the long-term wing, the nursing home. There, the NAs had not been following protocol to eliminate bulk feces from linen before sending it down chutes to the dirty linen room. She asks them to spend an hour there.

This becomes part of the annual mandatory in-service and orientation, and it solves the problem. The existential manager then turns her attention to the professional staff. Unit by unit, manager by manager, and leader by leader, she evaluates their effectiveness.

There is plenty of room for improvement. A timeline is established for them to boost their performance. Participation in formal management workshops is mandatory. Those in leadership positions without advanced degrees are expected to enroll in college and attend regularly until master’s degrees are obtained. This is all accomplished empathetically. Remember—empathy is an attitude that takes no additional time.
Those who cannot or will not participate are invited to apply for reassignment to nonleadership positions. The pathway to success is made clear. Individual needs can be discussed, and programs and outcomes can be modified accordingly. Harshness is not the goal. The objectives are personal, as is professional development and advancement in patient-centered care. Mentoring is offered freely and willingly.

Here are some questions to consider when working to achieve these goals:

■ How would you break the ice with a newly assigned staff person?
■ Would you take a different approach to elevate the standards, as discussed above?
■ What would be your first step if the other staff members were hostile to the newcomer? (Assume upper management allows you choices.)
■ What would you do if upper management occupied your time with redundant meetings? Would you just attend or specify your objections?
■ What are some actions you might take? Be specific.

At a subsequent NAs meeting coffee and cake were served to entry level staff for the first time ever. The kind of cake was left up to the food services department. They sent a tray of sliced pound cake. When the meeting was called to order by the newly appointed patient-centered/staff-centered CNE, a NA raised her hand. “This cake is not as good as the cake you served to the management staff at their meeting,” she said.

Momentarily taken aback, the CNE examined the cake. The NA was correct. Having several choices, the CNE could have said:

A. “I didn’t specify the kind of cake when I ordered it. This is what dietary selected.”
B. “Cake is cake, and this is the first time you ever had cake served at a meeting.” (The implication here is that the NA should not complain.)
C. “Thanks for pointing this out. Next time I’ll make equality a point of reference.”
D. “Why are you taking up the time of the group with minutiae?”
E. Other.

Consider the same scenario, except that staff members are not comfortable in their management environment, and they do not trust their new boss. They therefore do not feel free to speak up and register their dis-
satisfaction with the cake. So instead, they pass around notes in a stealthy manner which diverts their attention from the meeting.

The CNE becomes increasingly tense and annoyed, and this sets the tone for future encounters and relationships. From the NA staff members’ perspective, they believe that their new boss undervalues them, especially in comparison to the professional management staff. After all, they got better cake. Also, because they were concentrating on communicating with each other, they heard little of what was discussed. The meeting’s message becomes distorted, and when it is discussed later in the hallways, it bears little resemblance to what actually was said.

Amazing what a little cake can do.

Whether your staff is welcoming or hostile, keep your focus and language patient-centered. This is particularly important with an antagonistic or threatening individual or group. You cannot go wrong if you do not allow yourself to be diverted. Remember, you are there to improve patient care. To do that, you need a well-functioning team that keeps their eye on their subject of importance—the patient.

**Meeting Redundancy**

We bring together the best ideas—turning the meetings of our best managers into intellectual orgies. —*Jack Welch*

We all know what an orgy is—it usually has sexual connotations. But for the purposes of discussion concerning meetings, here is a more pertinent definition: an orgy is a period of excessive indulgence in a particular activity or emotion—especially something that has an element of self-pity.

I have had many conversations with nurse managers—those from the middle and those from the top, and I repeatedly detect dread (self-pity) attached to the word *meetings*. Many of these individuals have described some of these meetings as a waste of time, redundant, boring, tedious, and repetitive. It makes me wonder how many of these people have had a sit-down with their bosses and articulated the degree of interference these meetings have with their ability to do their jobs and to further patient-centered care.

I have asked. They have answered—darn few.

Here are a few questions for you:

- Have you assessed and analyzed a cost/benefit ratio for these meetings?
- What do you get out of these analyses?
Is there a less time-consuming way to obtain the information imparted at these meetings?

How much input do you have? How many nurse managers must attend?

Remember the most important question—have you discussed your opinion with your boss? But before you do, read on.

Apply critical thinking techniques to this problem. That is a topic, by the way, that we will cover later on in this book. But do not just sit back and not deal with the issues of meeting redundancy. Both patients and staff need your expertise. They depend on you to mentor, counsel, evaluate, demonstrate, lead them, and sometimes run interference for them. The question is: how can you accomplish all this if you are always at meetings?

**UNION/MANAGEMENT COLLABORATION, COMMUNICATION, COOPERATION**

Strikes are the epitome of conflict within a work environment. Unions have been known to block food, linen, personnel, essential equipment, and materiel from reaching sick babies and other patients normally dependent on caregivers now walking a picket line. Sometimes these individuals call their employers names. Sometimes they target their nonunion colleagues as well. If you have brought in temporary employees—strike breakers—woe be unto them as they walk across the lines.

Think how hard it must be for managers to traverse these boundaries without becoming angry with the staff members who have established them. Imagine what it must feel like to welcome picketers back once the strike is over.

It can also be difficult for staff members on a picket line who do not want to be there—those who believe that management has treated them fairly. They are compelled to participate even though they consider themselves valued and cared about by a management team who listened to their thoughts, complaints, wishes, and suggestions.

There is an axiom in labor relations that goes something like this: a patient-centered/staff-centered management team will make for an easier strike. Management has time before an impending strike to remind union-represented staff and nonrepresented staff that they are members of the same team with the same goals—to care for their patients. When the strike ends, they will come together as members of one patient-centered team. Therefore, it is in everyone’s interest to not bring shame upon themselves or their organization.
You might even tell them stories about some Japanese workers who take such pride in their organizations that their strikes are token walkouts. They want to make their point, but they do not want to harm their organization.

However, these techniques only work if they are true. Words are empty unless history and prior action back them up. The time to start a staff-centered management program is not right before an impending labor action. The stage must be set long before that. It might even prevent such actions—but not always.

Sometimes, despite staff-centered management, forces occur that are beyond your control. For example, your organization might be part of a large conglomerate that is facing a strike, and you are caught up in the conflict.

Whatever the situation, remember that the people on the picket line are your staff members. One day, the strike will end, and they will come off the lines to rejoin your patient-centered team. So visit your staff members on those picket lines and see to their well-being. Bring hot coffee in cold weather and cool drinks in the heat of summer. This approach can go a long way toward keeping the peace.

But strikes are only one part—a rare occurrence—of union/management interaction. Union-represented workers and management usually are on the same side—that of caring for vulnerable patients. We are on the same team. We work for the same employer. Nurse managers are responsible and accountable to those patients, and they cannot do it alone. It is in everyone’s best interest to develop a well-functioning team of diverse individuals and bring them together as cogs in a wheel.

In order to accomplish this, first they must get to know their team members—as individuals. Who are they? What motivates them? What are their work habits, their skills? Consider their strengths, personality types, proclivities, and weaknesses. People have different needs, but one thing is universal, and that is the need for respect.

Bad management means disrespectful management, and this opens the door to hostile relationships with union delegates who believe they must protect their members. This is not as simple as it sounds because one person’s idea of respect may be taken as disrespect by another. Suddenly, you are confronted by a hostile union delegate. When that happens, here is a mantra for you: “No appointment—no meeting!”

Do not relent. Hopefully, you have been schooled by your human resources (HR) department or others in interpretation and implementation of the contract. You will know what to do. What you should not do is drop everything and meet with the delegate without preparation—no matter how insistent or threatening that delegate may be.
Use the *phonograph technique*: keep repeating the same words—"I will not see you without an appointment. Please return to your work area." Do not give in.

Events like these happen rarely. In the chapter on labor relations, we will discuss contract interpretation and other important related issues. In the meantime, remember that union members are a part of *your* staff. Treat them as such, and include them in your staff- and patient-centered approach.

**Discussion and Points to Ponder**

- If you work in an organization in which staff is represented for collective bargaining by one, two, or even three unions, it is essential for you to have copies of the contracts and to understand those issues that pertain to day-to-day operations.
- Getting involved in contract negotiations, preparing the contract and related activities is extremely helpful. This aids in developing fluency in interpreting and applying those contracts.
- Involvement is also helpful in developing skill and comfort in preparing for grievance and discipline activities, but it is not enough. Discussion and role playing are important adjuncts that should be conducted with a labor relations/HR expert before you are called upon to actually participate in such activities. Remember, patient-centered care and safety is at stake. You do not want unsafe practitioners at your bedsides.
- Make sure you understand the concept of the management rights clause, as well as the contract language that states: "All other duties and responsibilities as assigned. . ."

This common clause in union contracts gives management personnel the right to assign workers to duties and responsibilities not specifically spelled out in the contract. This does not mean management can ask a NA to lay bricks. It does mean management can ask a worker to do something new within a job classification—such as add cleaning toilets to a housekeeper’s job responsibilities. In so doing, management must take into consideration staffing and the extra time it takes to clean toilets or make empty beds after discharge cleaning. In general, job descriptions belong to management. Prudent management discusses changes with the union, since a good working relationship should be cultivated. They do not, however, ask permission. The phrase, “the union won’t let us do it,” has no place in a well-run, patient-centered organization.

Now, ask yourself:
Have you established and maintained staff-centered relationships?
How do you know?
Do you know and care how it feels to be your subordinate?
What is it like to be a patient on your unit?

In my consulting experience, the vast majority of managers I have worked with on labor/management issues have never seen a contract, much less been instructed on its clauses or interpretation in the workplace. This makes them helpless in the face of intimidating employees or delegates telling them some things are either “not my job” or “not in the contract,” or words to that effect. If that happens to you, pull out a contract (or job description) and ask the employee to point out the effective clause.

**WALK A MILE IN MY SHOES**

Some organizations have a *walk a mile in my shoes* day, during which some staff members actually shift roles. This can be a real eye-opener if your subordinate is willing to imitate your behavior. Until that happens, some of us really do not know how we come across to others. As a substitute, try a round of unit conferences—wear masks, serve cake (I’m back to that again) and have a little fun. Humor in the workplace has been proven to ease tension and increase productivity. It even lowers blood pressure. If people are honest with you—or even if they are not—the question of how it feels to be your subordinate may be answered for you.

Here is how one CNE used humor to make her point.

She was the nurse executive of a world famous diagnostic center. Sometimes members of the Board of Directors—very powerful individuals—were extremely demanding. She often carried what she described as a “magic wand” to board meetings—you know, the kind you can get at Disneyland. When members of the board and medical executive committee asked too much of her, she would toss it on the table and say: “Here, this has stopped working for me, maybe it will work better for you.” This quickly broke the tension building in the room.

*To get back to the question of how it feels to be your subordinate, or a patient on your unit:* these questions are trickier. If I were a unit manager, I would talk to my staff members and to my patients and ask them. Then I would listen. As a consultant, I have done just that and have found that people love to talk about their experiences as long as they do not fear
retribution. Some have been pleased, while others have been visibly fright-
ened. Interestingly, but not surprisingly, there were several universal themes
to staff members’ concerns. At all levels, they complained about disrespect,
dishonesty, unfairness, untimeliness, and the like.

Patients, too, had certain themes. These included waiting for pain control
meds, the food, incessant noise, and rude, uncaring staff. I have heard these
issues articulated by my friends, people on buses, people on subways and
by people in Starbucks who have talked. The stories I have heard are what
motivated me to write this book. I wish I had heard stories of good, caring
experiences, but alas, that is rarely the case.

FLIRTING IN THE WORKPLACE

Is flirting a form of collaboration, cooperation, and communication? Is it
harmless fun, or insidious? When does it cross the line and become harass-

There was a support service personnel strike. I was the patient care
administrator at the time. Volunteers from a local nursing college provided
relief care. Suddenly, there was a commotion caused by a rush of all male
administrators to the ramp leading from the parking lot to the ER. I went to
see what was attracting them.

A sweet young thing wearing a mini skirt had sashayed across the picket
line and was gliding sensuously toward the ramp. She was braless under
her form-fitting T-shirt, and her long blonde hair swung provocatively with
each step. Watching the men watching the young woman was an interesting
stress-breaking activity during a difficult strike. But, as with all things, it had
a beginning and an end.

As she entered the building, I ushered her into an ER cubicle where
I obtained a set of scrubs and a loose-fitting lab coat for her to wear as her
uniform of the day. I then counseled her about professional comportment
and attire.

The administrators returned to their work assignments. In this case,
it was clear that no one felt harassed, but let us kick it up a bit and make
the student nurse a female nurse manager who was on a unit and got too
close to a subordinate nurse. As she leaned over him or her—provoca-
tively—she demanded he work an overtime shift which he did not want
to work.

There is a fine line between flirting and harassment, and it is often in
the minds of the people involved. Most would agree that the student nurse
was flirting. What would make it harassment? Perhaps if she were in a power position and her behavior caused discomfort to a subordinate. The higher the power/discomfort ratio, the greater the likelihood that it qualifies as harassment. That said, the greater the power of the harasser, the more likely it is that the victim will become upset and blow the whistle. That could trigger a lawsuit—or worse.

Here is another example: an employee health physician was known to add breast exams to his preemployment physicals. Is this flirting or sexual abuse? Or is it a necessary part of the preemployment physical? One day, a potential employee objected. He threatened her with denial of employment if she persisted in her refusal. She brought him up on charges of sexual harassment. During the investigation, other employees came forward. They had all felt abused but feared repercussions if they complained.

The physician—a contract employee—had his contract terminated and suffered other penalties. Unfortunately, the employees subjected to this harassment started their jobs with a negative experience, as opposed to feeling welcomed. One can only hope that staff members and patients were not subjected to similar behavior on the patient care units. The truth of the matter, however, is that human beings are sexual creatures, and flirting is part of human behavior. It is important that management develops trusting relationships with staff, so that they feel—there is that word again, feel—comfortable approaching their manager if they believe they have been threatened by sexually charged behavior.

**The ABCs of Patient-Centered Care: A—Administrative; B—Board; C—Collaboration, Cooperation, and Communication**

I am going to conclude this chapter with the letters A, B, C, but before I do, let us play a letter game that involves the letter P for philosophy. David Brooks of the *New York Times* wrote an op-ed entitled, *The End of Philosophy* (2009), in which he compares Socrates—who believed moral thinking requires reason and deliberation—with modern, cognitive scientists who see moral thinking as a matter of aesthetics. We *see* and we *evaluate* simultaneously. Reason and deliberation are not necessary to draw conclusions.

Brooks quotes Steven Quartz of the California Institute of Technology, who said during a recent ethics discussion sponsored by the John Templeton Foundation, “Our brain is computing value at every fraction...
of a second . . . What our brain is for is to find what is of value in our environment.”

Carry this into our world of nursing and health care, and into patient-centered and concomitantly staff-centered care. We know what it is and what it is not. We know it when we see it. We do not have to process it—not even for a second.

We also know that to implement any philosophy, Administration, the Board of Directors, and the Chief Executive Officer must generate and support it. They must all “walk the walk” and “talk the talk.” One would think that those at the top would model the brand. But in all the places I have visited, and all the well-meaning nurses, doctors, academics, and administrators with whom I have spoken, I have heard lip service instead of authenticity given to patient/staff-centered care. Too often, professional nurses are diverted to accomplish tasks better left to unlicensed support personnel.

I cannot explain why the industry persists in wasting money in so egregious a manner. It truly is penny-wise and pound-foolish—in the long run—to have RNs running errands, answering phones, wasting time at duplicative meetings, doing clerical work, and accomplishing a myriad of mundane tasks more efficiently left to others. Freeing them would allow RNs to focus their time on professional nursing care—on diagnosing and treating actual and potential health problems, restoring function, and saving lives. Instead, many professional nurses waste time and money working below their capacity and pay category. The ongoing need for communication, collaboration, and cooperation with those at the top is greater than ever as we move deeper into the twenty-first century. Health care reform at the bedside is no less important than it was in the Halls of Congress.

**SUMMARY**

This chapter concerns itself with the importance of creating positive empathetic, collaborative/cooperative relationships between and among the various entities within the health delivery environment. These include nursing staff and patients, nursing staff and leadership/management, nursing team members, the interdisciplinary team, nurse/physician, nursing/family members, nursing/vendors, and union/management.

- Understand the importance of cooperative, positive relationships among and between management/leadership and patients and staff. Attitudes are contagious. They flow downhill.
■ Praise publically, criticize privately; except in emergency situations. Try to role-model, mentor, and correct—not criticize.
■ Realize the importance of asking staff and patients how it feels to be a part of the organization and your unit—as well as how important it is for leadership to set the tone and direction for patient- and staff-centered philosophy, goal setting, and implementation.
■ Shift from egocentric communication—the I’s have it—to patient-centric communication—the patient needs it—or the unit needs it to enhance communication, cooperation, and collaboration.
■ Bring supplies and equipment to point of service whenever and wherever possible. Do not waste precious staff time searching for supplies and equipment.
■ Improve listening skills to enhance communication and establish trust.
■ Develop relationships with A—Administration, B—Board, and C—CEO.

CHAPTER ENDNOTES
