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Back to the Future

Learning From the Past to Prepare Competent Nurse Leaders for the Future

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If today's need for highly competent nurse leaders is urgent, and there seems to be no controversy about this fact, what will be the need in the next few years? And what will ensure the availability of these highly competent persons? Between the opportunities offered by the Accountable Care Act, and the IOM Report on the Future of Nursing's recommendations, the consensus is that the need will be great. This is not a new concern: During the 1960s, the pendulum in graduate education in nursing swung from functional preparation in teaching, supervision, and administration to clinical specialization. While the change was a logical one, inadequate consideration was given to the preparation of people who would fill these roles in the real world. Consequently, Boston University School of Nursing held an invitational conference in 1978 to respond to the call for preparation of competent nursing leaders. The author interviews some of the leaders who attended and/or presented at this conference to see just how much we could learn for the past to apply today. **Key words:** *leadership, chief nursing officer, education, professional development*

"What little progress we made in developing nursing administration as a clinical specialty has been watered down in the last 20 years." said Muriel Poulin, RN, PhD, FAAN. "The *only* way we will be able to have, and to hold onto, the authority we need at top levels of decision-making is for the profession to prepare nursing administrators appropriately and at the highest level. After 40 years, what the profession needs is to *make this happen*!" Now *that's* saying it like it is! Moreover, Poulin has the full authority of the Institute of Medicine's (IOM's) recent study of *The Future of Nursing*[1] behind her—not that she needs it!

The IOM's report, particularly recommendation 2, places nurses *at the table.* To wit: "... Expand opportunities for nurses to lead and diffuse collaborative improvement efforts. Private and public funders, health care organizations, nursing education programs, and nursing associations should expand opportunities for nurses to lead and manage collaborative efforts with physicians and other members of the health care team to conduct research and to redesign and improve practice environments and health systems. These entities should also provide opportunities for nurses to diffuse successful practices." But what good does it do nurses and the nursing profession to be *seated at the table* if they don't know how to participate effectively and influence profoundly the other players at the table.

As I thought about this issue—that of the effective preparation of nursing leaders—I remembered a conference on this subject held over 40 years ago. It sponsored by Boston University School of Nursing and chaired by Muriel Poulin.[2] In fact, many of the papers presented at the conference were published in *Nursing Administration Quarterly*.[3] With

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this in mind, I contacted Dr Poulin who at 86 is still very active and involved. While a number of those who were invited to attend this conference have died, a number are still living and still very involved in nursing—and I decided to track them down and interview them for this issue. I conducted interviews with 3 of these leaders—Muriel Poulin (retired), Leah Curtin, RN, ScD(h), FAAN (executive editor, American Nurse Today), and Margaret McClure, RN, EdD, FAAN (professor, New York University)—to determine what changes they had seen in the 40 years since the conference—with some room for speculation about why or why not things changed.

I have collated their answers and placed each under the questions themselves.

1. Is today's chief nursing officer (CNO) as powerful as yesterday's superintendents of nursing? Why or why not?

   Muriel Poulin: The answer depends on how far back you want to go. If we go back about 20 years, then I have to say that it depends on several factors. If the chief nursing officer is fully qualified and works in a large institution, then the answer is "yes." In fact, she is more powerful than those who served in that role 20 years ago. In smaller institutions, I think that doctors still run the hospital.

   Leah Curtin: I do not believe that today's CNO is anywhere near as powerful as yesterday's superintendent of nurses. Yesterday's superintendents of nursing generally were what we call today the chief executive officer (COO) of a hospital:

   > Hospital superintendents were identified in hospital bylaws as the institution's executive head. For example, the rules and regulations of Memorial Hospital in Worcester, Massachusetts, noted that "the Superintendent . . . under the direction of the Trustees, shall have the management of both the Hospital and the Dispensary, including the control of all subordinates, employees, domestics, nurses and patients and the care of the grounds, buildings, and appurtenances' (Memorial Hospital 1912, 2) Bylaws also enumerated specific areas of responsibility for the superintendent, such as the appointment, control, and discharge of employees; maintenance of permanent patient records; acting on applications from patients for admission to the hospital; keeping records of monies and gifts received, bills incurred, and inventories; purchase of provisions and supplies; oversight of housekeeping; and preparation of budgets and reports to the board (Memorial Hospital 1912; Milford Hospital 1913; Sturdy Memorial Hospital 1914).[4]

   And the *superintendents of hospitals usually were nurses* (Parnall 1920; Redwine 1917; Riddle 1912).[5]

Margaret McClure: I have never been a "superintendent of nurses," but if you go back far enough (in the 1890s and 1900s) then the answer is *no*. In those days the superintendents of nurses functioned as hospital administrators. However, if we are talking about the time during which this report was written, which was over 40 years ago, then yes—in fact much more powerful. It varies, of course, according to the size and type of organization—and a number of other factors. However, as a group, today's CNOs are very powerful.

2. As about half of today's CNOs have no preparation beyond their first degree in nursing, one must ask "should the chief nursing officer have graduate education?" and if so, why? And who does decide—and who should decide this matter?

Muriel Poulin: It is somewhat shocking to me to think that so many nursing administrators are so ill-prepared for their role! I can only think that they must be working in smaller, community-based institutions and nursing homes. That, and I am guessing that many of them are prepared in business administration or something related. In my opinion, a CNO should have graduate preparation in *nursing administration*.

As for who should decide the educational preparation of the nurse administrator, it should be the *profession.* The problem is that the profession itself views this as a *functional* role—and defines *clinical* preparation only in terms of hands-on nursing. Nursing administration is not hands-on in that sense. However, nursing administration is a clinical specialty. Nursing administrators determine the actual practice of nursing—how it will be practice, what roles will be filled, staffing levels, deployment of resources, even to a large extent, what credentials will be required to fill certain positions, how quality will be measured, etc. In fact, the CNO influences every aspect of the practice of nursing. But until the profession is willing to acknowledge this, and develop the kinds of educational programs needed to prepare someone adequately this for this role.

Leah Curtin: There is little controversy about the facts: the educational preparation and experience of the CNO in hospitals vary widely by hospital size, location, and affiliation. Only one thing is certain—they are all registered nurses because state laws throughout the country require it. Laws are often subject to public pressures, and over my years in nursing, certain pressures—most notably those brought on by management consulting firms—have urged the hospital industry to lobby to have this requirement abolished. So far, this effort has not succeeded. However, for a time in the late 1980s and 1990s, many Hospital CNOs were stripped of line authority (some still are) and retained as "staff" to the hospital's chief operating officer (some CNOs have become COOs) or chief executive officer (a post that other CNOs have now taken).

For what it is worth, I believe that CNOs need graduate education to deal with the increasing complexity of today's hospitals and health systems. Cer-

tainly, in university-based hospitals, the CNO needs a doctoral degree in order to command the authority to fulfill her/his role in this environment. Otherwise, an undergraduate degree in nursing followed by a master's degree with a dual major in nursing/business administration or a related field is sufficient. Because of the importance of finance today, some CNOs are seeking graduate degrees in accounting/finance. I do not think this is a good move (although many CEOs are former chief financial officers) because it is too narrow—too restrictive—to prepare someone to take a leading role in running hospitals.

Now for the question "Who does decide, and who should decide what preparation the CNO needs," I believe that the profession of nursing itself should decide this question through nursing organizations (AONE, AACN, ANA) collaborating first together and then with graduate programs in colleges and universities. Who actually decides? For all intents and purposes, the industry decides. The CEOs decide—even though there may be search committees and so forth—in the final analysis, the CEO hires whom he/she chooses for this role. Can this be changed? Certainly, regulatory bodies (like Centers for Medicare and Medicaid Services, CMS, and state hospital accrediting agencies) and legislatures could mandate minimal educational requirements for CNOs. So far, this has not happened—nor do I think it will happen in the near future.

Margaret McClure: Certainly, most CNOs in hospitals have graduate education, although not always in nursing, which I think is a mistake. I think that CNOs need a graduate degree in nursing because they head the largest clinical department in the hospital. Health care administrators are a dime a dozen, but CNOs stand out because they are nurses. Just as the chief of surgery has to be Board Certified in surgery, so the CNO needs documented expertise in nursing. While they certainly must know business principles, accounting, human relations, and so forth, what is really important is that they are expert nurses. However, many of our colleagues find that having a graduate degree in nursing as well as an MBA not only helps them perform well but also increases their credibility with other administrators.

3. What is the primary focus of the chief nursing officer's role and responsibilities?

Muriel Poulin: The focus of the CNOs role is the delivery of nursing care to patients. Whether or not their role is expanded to cover other clinical areas, the bulk of the CNOs responsibility invariably is nursing if for no other reason than that the bulk of the employees are nurses. As for whether or not nurses should be in such roles as that of the chief operating officer, all I can say is that it depends on what the COO's duties include. If they include patient care, then the answer is an unqualified *yes*.

I have always thought that the *conceptual framework* that underlies administrative decision making is critical. And that conceptual framework must be in nursing where patient care is concerned. Business schools, and even schools of hospital administration focus elsewhere—on the bottom line, on efficiency, on marketing or accounting—on almost anything but patient care.

Leah Curtin: The primary focus of the CNO's role and responsibility is to assure that all patients receive safe care. The secondary focus is to assure that personnel are treated justly, that opportunities for education and advancement are equally distributed throughput the workforce, and that the efficacy of patient care is advanced. The third, but by no means less important foci is to practice careful stewardship in the distribution and placement of human and

material resources. Certainly, the ability to introduce change must also be added to the previous three.

Margaret McClure: The primary focus is to allocate resources in such a manner as to enable nursing to be practiced well—the best it can be. And she or he has to willing and able to spend money to optimize staffing to assure patient safety.

4. If you agree that chief nursing officers need graduate education, what courses should be included in her/his preparation?

   Muriel Poulin: I absolutely agree that the CNO needs to be prepared at the graduate level. Moreover, I believe that the programs should be housed in Colleges of Nursing and that way nursing and patient care provide the conceptual framework for the management and administrative courses that are essential to their preparation. Otherwise, the student will lose her/his focus on the patient. I have said this before, but it is worth repeating: the leader's *conceptual framework* is critical because consciously or unconsciously, it will inform all decisions. But, it is also critical that general management and administrative courses form the bulk of the graduate curriculum.

   Leah Curtin: Assuming that the graduate students all have a BSN, I think that preparation for the CNO role should include courses in Logic, Inductive and Deductive Reasoning, Professional and Business Ethics, Health Law and Regulation, Personnel Management, labor Relations/Negotiations, Organizational Behavior, Basic Probability and Statistics, Financial Accounting, Corporate Strategy, Microeconomics, Change and Change theories, Macroeconomics, Decision Models, Corporate Finance, Marketing Strategy, Leadership, Operations Management, and Communications (writing, elocution, speech, media management).

   Margaret McClure: There is no doubt that the graduate preparation should be in nursing. The real question is how much clinical preparation do they need? It isn't possible to give them everything—and they need so much to fill the role effectively. This debate will continue!

5. Is the CNO primarily a nurse in a senior executive position—or primarily an administrator who has responsibility for nursing services?

   Muriel Poulin: The CNO is a nurse in a senior executive position. Period. Full stop.

   Leah Curtin: The CNO is primarily a nurse who is educationally and experientially prepared to be in a senior executive position. It is crucial for CNOs to understand that the primary reason they are in this executive position is the fact they are nurses. Nursing is their power base, and they abandon it and give their primary allegiance to the "executive team" at their own peril. The core business of the hospital is the clinical care of patients, and the CNO represents the largest body of clinicians in the hospital—and, in many instances, represents all core clinical divisions with the exception of Medicine. Understanding what is essential for the safe care of patients and also understanding the ethical focus and concerns of practitioners are key to successful role fulfillment.

   Margaret McClure: The CNO is a nurse first, the leader of a clinical practice.

6. Should graduate preparation in nursing administration be a "clinical specialty" in a college of nursing—or should it be a concentration in a program in business administration?

   Muriel Poulin: Yes, because they control the practice of nursing. Researchers are not hands-on nurses, yet they are included because their work expands and informs the work of nurses. Administration also ought to be a clinical specialty

because their work controls the practice of nursing. It is not merely a functional role—and it is critical for colleges of nursing to recognize this and provide appropriate education for this role. I do not think that business colleges can do so for the simple reason that they do not and cannot know what is necessary for patient care.

Leah Curtin: Ideally, education for CNOs should be housed in a school or college of nursing—as a specialty at the graduate level—although not as a "hands-on" specialty. It would be ideal to have graduate faculty from the college of nursing and the business college (or the graduate program in health administration), codesign and co-teach the courses. Some CNOs have accomplished this by getting both a masters in nursing and a masters in business administration. However, I do think that this is an undue burden on future CNOs.

Margaret McClure: I have already answered this question: graduate education for the CNO should be housed in a college of nursing.

7. Is leadership conferred through a title or is it a skill that the person can develop? If leadership is a skill, what is the best way to develop it? If it is an inborn characteristic, how can we identify and select who have it?

Muriel Poulin: A title does not confer any kind of leadership. Certainly we have people with the right title, but they are not leaders! Yes, one can develop some of the skills a leader needs. They can be developed, as the student is exposed to the theory and knowledge necessary—that is, they must have the qualifications. Certainly a history of excellence in nursing practice is desirable, but it is no substitute for mastering the necessary skills: human relations, interviewing skills, economics . . . . Simply promoting a clinical nurse, however excellent she/he may be, is not enough.

Leah Curtin: I firmly believe that leadership and management are 2 different functions. To put it simply (if not simplistically), *managers* are those who learn *HOW* to get things done—how to get from point A to point B. *Leaders* are those who envision the possibility of a point B, and who can inspire others to share this vision. While it is possible that a manager could also be a leader, and that a leader could also be a manager, it is by no means necessary. What is necessary is that managers learn to value, and listen to, leaders, and that leaders value, and surround themselves with, capable managers. Management can be taught—and then practiced to hone the skills. Leadership is experiential, and its development depends on a combination of factors: inborn characteristics, opportunities, and the presence of willing and able mentors than on any other single factors. In short, one becomes a leader by being a leader who is led by and groomed by other leaders.

As for how we will identify them: this is not a problem because they self-identify. They can and will stand out because they will find ways of improving practice. They will make suggestions. They have a lot of energy and are not easily overwhelmed. Because they are intelligent, they may not be easily led. When you spot such a person, take her/him under your wing, and mentor them—giving them incrementally more responsibility and authority. This is the most critical part of leadership development: leadership is not learned from a book. You learn to lead by leading. So, let this person lead—you stand in the background and help, if needed. But their authority and accountability must be real!

Margaret McClure: Almost every quality that human beings have manifests as a talent. Some people have a talent for leadership and some do not. It is no unlike musicians; they must have

talent to be practitioners but then they require a great deal of training and practice to excel. So, it is with leadership. Some people are just tone deaf; they simply do not have the raw material to become leaders. And they cannot be taught to be leaders. Undoubtedly they have real talents for other areas of nursing. However, if they do leadership talent, it needs to be developed and polished. You will spot those with leadership talent—like cream, they rise to the top. When we identify them, we need to make a point of developing them. Again, like the musician, they need daily practice. They need to study and work at it.

8. What have we learned about the role of chief nursing officer over the 40 years that have passed since the Kellogg foundation's report *the education and roles of nursing service administrators*?

Muriel Poulin: I do not remember enough about that study—after all, it was 40 years ago! However, I do think that what little progress we made in developing nursing administration as a clinical specialty has been watered down in the last 20 years. Does the Doctorate in Nursing Practice solve this issue? It really depends on what is in the curriculum, but I do not think so. We have not solved the problem of the appropriate preparation of the CNO, and we will not until the profession itself recognizes its importance as a *clinical specialty*. We, as a profession, still look down on management preparation. Yet, the *only* way we will be able to have, and to hold onto, the authority we need at top levels of decision-making in hospitals and health care systems is for the profession to prepare nursing administrators appropriately and at the highest level. After 40 years, what the profession needs is to *make this happen*!

Leah Curtin: We have learned a great deal about the demands of the role. However, I am very sure that the role has, and is continuing, to change and, if anything, become more complex and demanding than in the past. Famed management guru Peter Drucker allegedly described the modern hospital as "the most complex social organization ever designed by man" at least 25 years ago. And in these ensuing years, hospitals have become health systems that engage in inpatient, outpatient, fitness, holistic health, insurance, health maintenance, disease management, medical home, physician offices and specialty clinics, research facilities, educational (both formal and continuing), end-of-life, and home care services. They have become "holding companies," which house a variety of for-profit and not-for-profit ventures and employ individuals whose backgrounds range from barely literate to those with advanced degrees. And now, it is more than likely that, under the new health reform act, accountable care organizations, medical homes—and perhaps even health insurance exchanges or cooperatives may be owned and operated by these "hospital" holding companies. Every hospital differs from all others in literally thousands of ways. These differences exist even among peers that share the same basic mission and challenges. In short, many "hospitals" have become mega-matrix corporations—and the CNOs roles (the plural is intentional) within them vary according to their placement within the corporation. In fact, it is fair to say that there is not one "CNO role" anymore, except perhaps for the "beginning" CNO . . . the first step within this complex matrix.

Margaret McClure: The role of the CNO today has changed so much as compared to 40 years ago that it is barely recognizable! The role is so complex now. It is amazing that some people still do not respect the role, often saying that those who cannot practice will manage. Of course, they have never been in the

role, and they have no idea just how complex and demanding it is! I have the utmost respect for the talent, abilities, and commitment of today's CNOs. My hat is off to them!

In 1979, Muriel Poulin wrote of this conference "there was a general consensus that the nurse administrator's main responsibility is to ensure the provision of nursing care to people. However, there was considerable ambivalence about the focus of the role. Some feel very strongly that administration is the focus . . . Others feel just as strongly that clinical nursing content should be the focus of graduate study."[6(p46)] Our 3 experts agree: the focus role of the CNO is the delivery of safe care to patients.

In 1979, conference attendees concluded that "It is clear that the nurse administrator is the leader for nursing in the agency. It is equally clear that such a position requires strong management and leadership competencies."[6(p47)] Our 3 leaders (past and present) agree. However, they all support graduate education in nursing for CNOs with as much business education as possible. But if there must be a choice between the two: graduate preparation in nursing is preferred. Moreover, The AONE's *Position Statement on the Educational Preparation of Nurse Leaders* clearly states that "(1) The AONE Nurse Executive Competencies[7] should form the foundation for all graduate nurse leader education and curriculum development. (2) Nurse leaders should be minimally prepared at the baccalaureate and masters level in nursing. (3) As nurse leaders assume more responsibility for specific units, departments, service lines or system level roles, the minimum educational preparation should be at the master's degree level. (4) Nurse leaders at the highest levels of executive leadership are encouraged to seek educational preparation at the doctoral level."[8]

Many of the issues are the same, but the role of the CNO has grown dramatically: it is more complex, more demanding—and more powerful than at any time since the superintendents of old gave way for the MHAs of the 1970s.

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