Nurses as Leaders
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Nurses as Leaders
Evolutionary Visions of Leadership

William Rosa, MS, RN, LMT,
AHN-BC, AGPCNP-BC, CCRN-CMC, Caritas Coach

Editor
For Mom and Dad,
Beatrice and William Rosa Sr.,
for showing me love so that I might love,
for teaching me kindness so that I might be kind,
and for leading me with integrity so that I might lead.
I love you.
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CONTRIBUTORS

Jean Watson, PhD, RN, AHN-BC, FAAN, is distinguished professor and dean emerita, University of Colorado Denver, College of Nursing Anschutz Medical Center campus, where for 16 years she held the Murchinson-Scoville Chair in Caring Science, the nation’s first endowed chair in caring science. She is founder of the original Center for Human Caring in Colorado and is a fellow of the American Academy of Nursing, past president of the National League for Nursing (NLN), and founding member of the International Association of Human Caring (IAHC) and International Caritas Consortium (ICC). Dr. Watson is founder and director of the nonprofit Watson Caring Science Institute (WCSI).

Dr. Watson has earned undergraduate and graduate degrees in nursing and psychiatric–mental health nursing and holds a PhD in educational psychology and counseling. She is the recipient of many awards, including 11 honorary doctoral degrees. At the University of Colorado, she held the title of distinguished professor of nursing, the highest honor accorded its faculty for scholarly work. As author/coauthor of more than 20 books on caring (including American Journal of Nursing Book of the Year award winners), she seeks to bridge paradigms as well as point toward transformative models for the 21st century. In October 2013, Dr. Watson was inducted as a Living Legend by the American Academy of Nursing, its highest honor.
Foreword

When I was a little girl, I was sure that all the issues and problems would be resolved before I had a chance to make a difference. I had no idea that making a difference was a leadership role. I had myriad questions, ranging from “How would anyone ever know that I wanted to make a difference?” to “Would I ever be equipped with the knowledge, courage, and compassion to make that difference?”

*Nurses as Leaders: Evolutionary Visions of Leadership* would have been—and is—incredibly reassuring. For this book is full of reassurance from leaders who have made and continue to make a difference in the world of “health nursing,” as Florence Nightingale would have called it. In these pages, you will find bridges connecting the leaders, shaped and molded by time and challenge, with those leaders delicately—and, sometimes, hesitantly—touching the newness of leadership. These bridges are awe inspiring. As you read, you will discover the opportunity to walk in the shoes of some of our well-known giants and, by simply continuing to read, you will find yourself in the shoes of those beginning or midway in their careers.

Amazingly, I still hear the anxiety emanating from both leadership sectors. From the well-developed leaders, I hear the echo of “Who will be my successor?” and from our formative leadership colleagues, “Will there be room for me in the arena often reserved for professional pioneers?” The chapters identify the trials of climbing the mountain to make contributions to the health of the nation and the global community. You will bump into teachable concepts like visioning, praxis, and resilience.

As the leadership dynamic unfolds, visioning tends to take center space. But visions cannot stand alone. So, in appreciation of praxis (moving the concept into action) as related to a vision, it is clear that a vision without action is a hallucination. The authors of the chapters present their testimonies of action and the challenges incurred along their life journey.

Interestingly, the precedent to a vision is the ability to dream, to see one’s self in the role of leader. The writers invite us into their dreams and the evolution of their leadership. This book illustrates the links between the dream, vision, and action that so many of these leaders have practiced. With formidable resilience, it becomes clear that there really are multiple paths to leadership and to making the difference. Rather than a fork in the road with just two options, there frequently are many choices. Often, upcoming leaders lack clear planning or miss an opportunity due to life events and only later realize that the humility learned from those very events make one a better, more complete leader.
So, this is a book for little girls and little boys who lack the confidence that there will be issues and problems to resolve when they grow up. It is for the emerging voices that shout of a new time, a new day for health care; for the professional pioneers who can see their fingerprints on some of nursing’s most notable innovations and discoveries of learning; and for the faculty who struggle with how to transfer the hunger for leadership and the humility to accept it to their students and, at times, to themselves. This book is a gift to mentors and mentees who continually build bridges of collaboration, partnership, and learning, and it challenges us to make a difference in the world of health and caring.

This book of leadership is for you.

*Beverly Malone, PhD, RN, FAAN*
CEO, National League for Nursing
Preface

leadership [asks]:

Do we have the courage to . . . show up . . . take risks, ask for help, own our mistakes, learn from failure, lean into joy, and . . . support the people around us in doing the same? . . .

[It] requires leaders . . . willing to . . . show up as imperfect, real people.

That’s what truly, deeply inspires us.

—Brené Brown (2012)

In the 1870s, Florence Nightingale wrote that it would take 150 years to see the full embodiment of nursing as a profession—the kind of nursing she envisioned as its founder and first pioneering leader. She saw nursing as a calling and a must—a discipline without boundaries or limitations, built on a foundation of unrequited service to the public and globally relevant in research, education, journalism, clinical practice, policy, science, and environmental activism. As the year 2020 and the 150th anniversary of the aforementioned prediction approaches, nurses and nursing stand on the precipice of realizing this expansive professional aspiration. This book strives to usher in this Nightingalean ambition as its very aim and purpose.

The contributions compiled herein invoke the actualization of a mighty and innovative possibility, one that merges all corners of the discipline into a cohesive force for health and well-being; fully embraces the art and strategically engages the science of nursing; provides historical context and evolutionary foresight; and seeks to unveil and awaken the inherent leader dwelling within each nurse, regardless of position, title, credentials, or specialty. This book assumes that every nurse is a leader and provides guidance, opportunity, and the vision necessary to support making that leadership manifest in the world.

Nightingale proposed three sacred tenets of nursing foundational to the vitality of the profession and the health of the world at large: healing, leadership, and global action (Dossey, Selanders, Beck, & Attewell, 2005). As healers, we have defined scopes and standards for practice that are nursing’s prerogative, specializing in the care of unique populations and translating humanistic and empirical paradigms into measurable outcomes. As global activists, we have advocated for the patients and families we serve across cultures, continents, and considerations and have positively impacted global health advancements through myriad contributions to research, education, and practice arenas. But as inspired
and emboldened leaders, though the successes and accomplishments are many and the recognition from multidisciplinary partners substantial, we continue to fall just short of our highest collective potential: a unified, empowered, visionary, and globally informed profession, capable of redefining health care and creating a new understanding of health and well-being for ourselves and those we care for. We do not yet believe that we are the very ones we have been waiting for.

The World Health Organization (WHO; 2012) identifies us as the largest group of health care providers, with the number of nurses and midwives worldwide estimated to be well over 19 million. In the United States alone, nurses are represented by more than 200 state and national organizations (Matthews, 2012; Nurse.org, 2014–2015). We are positioned and mobilized for exceptional leadership opportunities—the “backbone of health care”—yet we remain divided over keystone issues and professional–cultural challenges. Internationally, disagreements persist over the entry-level degree requirement for a registered professional nurse and whether mandated nurse:patient ratios should be enforced. Interpersonally, horizontal violence still runs rampant in a multitude of settings, and nurses suffer from unacknowledged or disregarded symptoms of compassion fatigue, burnout, and moral distress. Conversations about the lived experience of each nurse—the challenges, frustrations, upsets, joys, and loves—often go unspoken; their candor and authenticity often unwelcome in an academic, quantitatively driven milieu. However, these are the conversations that hold the potential power of transformation. They require courage and fortitude and the audacity to be vulnerable, and they give voice to the unseen work of nurses and nursing. They are the stories and genuine expressions of humanity that have the potential to guide the profession from fragmentation toward wholeness.

This book forges an untraversed landscape of leadership in action—articulating the invaluable work and professional contributions of current-day nursing frontrunners, humanizing their experiences in a way that is accessible and tangible to the reader and creating a powerful worldview of possibilities for how nurses see who they are and what they are capable of achieving. These writings—composed by innovative and seasoned clinicians, nurse educators, deans, chief nursing officers (CNOs), executives, acclaimed authors, global advocates, policy experts, holistic guides, nurse coaches, editors-in-chief, organizational presidents, nongovernmental organization (NGO) founders, spiritual practitioners, and administrators—provide novice and beginner professionals the opportunity to arouse their own potential for nurse-driven leadership and explore realms beyond the finite outlines of traditional curricula. More experienced readers will have access to voices that support and nourish their need for professional development, wherever they are on their career path. Established leaders in nursing will be given ample and diverse opportunity to reflect on all aspects of their journey to date, as well as insightful considerations for their trajectory ahead.

The offerings of these authors and the tables they have earned seats at have disproven the notion of nursing as a historically subservient, “blinders on–bedside only” role and have elevated it to one of tremendous communal, societal, and global impact. This book introduces a first in nursing: subjective access to the inside details of this individual–collective journey and real-world education that flows from the richness of personal experience and professional wisdom. Each author has mastered an artful approach to writing, infusing the intimacy of personal storytelling with the science of
scholarly expertise. This collection has the potential to create a mutually beneficial symbiosis for praxis between authorship and readership; a dialogue that serves as proof of theory in action as authors illustrate how their careers and life paths have exemplified their individual philosophies of nursing; an interplay that seamlessly merges the personal and professional. Never before has such a seemingly disparate group of authors been able to present their work side by side to create a unified front for nursing—a living testament of theory informing practice informing theory and so forth.

The authors write of their relationship with nursing and what drew them to the profession, the circumstances and experiences that sparked their interests and passions, their evolution within and contribution to the discipline, the morals and ethics that guide their practice, and their individual vision for a wholly embodied and fully expressed future of nursing. In essence, the contributors outline the part of the work, the area of their specialty, the heart of their purpose that has yet to be realized, so that up-and-coming nurse leaders may continue to expand upon it with confidence, direction, and intention.

Through their artistic and scholarly approach, they outline the being, or current status, of the discipline while pointing us toward its very becoming. In this way, these writings move beyond a demonstration of leadership in action and become succession planning in action. Readers are handed both a guidebook and compass for personal–professional growth through the intimate narratives of nursing's most adventurous pioneers, boldest activists, and emerging voices.

The book is divided into two parts. Part I, “Laying the Groundwork,” includes chapters from renowned leaders who discuss aspects of their professional contributions in detail and guide the reader to unleash his or her future potential through the lens of nursing. These chapters deeply connect the reader to one of the main intentions of the book: to assert and validate that nurses and a nursing sensibility are vital for the continued evolution of humanity and to ensure that dignity, humane caring, and compassionate, courageous leadership continue to pave the path for the profession and beyond.

Part II, “Building the Inroads,” encapsulates the experiences, messages, work to date, and future directions of accomplished and inspiring nurses who are continuing the conversations started by those who have laid the groundwork or claiming a new domain with which readers can co-identify. These authors are adventurous scholars, doctoral students, and change agents who are continuing to shape the voice of the collective. Part II further provides alternate views of nursing as a discipline, promoting leadership capacity for the reader and encouraging individuality and authenticity in nursing praxis.

Each author’s vision has been abbreviated and condensed to create their respective chapter title. Whether they view the full potential of nurses to be “translational and indispensable,” “metaphorical and passionate,” or “unitary and appreciative,” the title of each chapter is an invocation for the future of the profession as it relates to the author’s work. In fact, it is more than an invocation; it is an extension and reminder of the 150-year-old Nightingalean vision. Each author becomes an expert scholar and theorist in his or her own right, offering a lens through which to embrace, engage, and evolve nursing praxis. Reflection questions at the end of each chapter guide readers to contemplate presented concepts, merging the message of the authors with the individual perspectives of readership and grounding visionary possibilities in personal understanding and practice.
This book can be used as a primary text for undergraduate leadership and management courses; by graduate nursing administration students; as an adjunct book for nursing theory classes; and by those interested in deepening their understanding of global nursing, getting involved in policy and advocacy work, or fulfilling the potential of their role as advanced practice nurses. It is a tool for professional development specialists to guide the staff members they serve, a reference for managers to inspire their employee partners, and a resource for teachers to elevate the consciousness of students. It is a historical primer for those interested in how we got where we are and an action plan for those who want to be effective change agents. The novice can use it to encourage yet-to-be-known aspirations, and the expert will be humbled by its gentle return to nursing’s most basic foundational values. The bedside clinician will find its bird’s-eye perspective illuminating and the public health community worker can find inspiration to reintegrate the intimate specifics of human-to-human, one-on-one caregiving in an environment of cultural humility. More than any other single volume on the market, *Nurses as Leaders: Evolutionary Visions of Leadership* documents and celebrates the far-reaching, transcultural, and multidimensional impacts that nurse leaders have made and the guidance they continue to provide in health care and beyond. **Qualified instructors may obtain access to ancillary instructor’s PowerPoints by contacting textbook@springerpub.com.**

It is now up to you, the reader, to map out the journey and claim it as your own. After laying the foundations and building the inroads, the unwritten third part of this book will arise from what you choose to do with the insights provided. The next chapters will be lived out in how you translate this wisdom into everyday practice and the ways you choose to shepherd the profession as an evolutionary nurse leader. We will only realize our collective leadership potential when we, as a profession, become clear about what and how we are leading, and why our leadership matters.

This book is essential as we currently face the overt medicalization of the nursing profession and a disconnection from our unique and altruistic culture, with the resulting submergence of the ethic and ethos of nursing as both art and science. If nurses can no longer articulate what makes theirs a specialized profession, clearly express their thoughts, feelings, and emotions with confidence and consistency, or identify the challenges in the world they can address directly as the vanguards of human caring, then they will cease to be just that: nurses. At this moment in our professional development, our patients, colleagues, interdisciplinary partners, politicians, and the global society at large look to us for answers, guidance, and unwavering leadership. It is imperative that we remember who we are and who we were always meant to be as a collective. It is essential that we both claim and fulfill our individual roles as leaders for the betterment of ourselves and of those we serve.

It is time.

*William Rosa*

**REFERENCES**

Acknowledgments

My friend and the author of the first chapter in this book, Jeanne Anselmo, wrote me a note some time ago that reads: “There is a great wealth of wisdom, compassion, innovation, vision, heart, diligence, insight, understanding, and love in our Nursing community that is not often given a venue to constellate and shine its light.” I could not agree more.

I am deeply grateful for the countless nurses, change agents, leaders, mentors, teachers, students, and colleagues who have inspired me along my journey and whose impact on me has led to the realization of this book.

To the authors whose lived experiences grace these pages, there are no words to express my gratitude for you and your vulnerability, courage, and leadership. You are the vision! You are the living proof of what nursing can and might be. Thank you for trusting me with your stories. Thank you for taking a risk on a first-time book author. And thank you for your kindness and generosity as we partnered to ensure the integrity of this project.

Endless thanks to Springer Publishing Company for supporting me throughout this process.

Deep gratitude to my publisher, Margaret Zuccarini, for giving me this chance and believing in me from the start. Thank you for your caring presence and encouragement.

Amanda Carswell, Kris Parrish, and Jacob Seifert, thank you for your dedication to this project, for your quick responses, and for your patience as I navigated this learning curve.

Dr. Wendy Budin, without you, this book would not exist. Thank you for being you.

To my first nursing family at New York University Langone Medical Center, I am eternally grateful for all you have taught me over the years. I am thankful for your friendship and support. To the staff nurses I have worked with in the Critical Care Center, you are the most incredible and gifted group of people. Thank you for teaching me how to be a nurse and for inspiring me beyond words. To my nurse educator friends and colleagues, you have each taught me, in your own way, what it means to be of service through leadership. Loving gratitude to Roseann Pokoluk—thank you for your generous and unwavering support, your honesty, for always believing in me and for always giving me the chances I needed to grow and lead.

Thanks to all my teachers at the New York University Rory Meyers College of Nursing and the Hunter–Bellevue School of Nursing at Hunter College, especially
ACKNOWLEDGMENTS

Dr. Grace Ogiehor-Enoma for being the very first teacher who made sure I knew that my ideas were “good enough” and that I needed to get clear about how I would lead.

To my caring science family, thank you for your magnificent and healing community. Special thanks and much love to Dr. Jean Watson, thank you for always being available to me, for always treating my words, thoughts, and dreams with kindness and openness, and for your constant support in all I do.

Many thanks to the International Nurse Coach Association (INCA) for creating new possibilities of leadership for nurses. A note of gratitude to Barbara Dossey, for your unending support in this project; and to Susan Luck, thank you for being a part of this, even in the face of challenging circumstances—your dedication to this book has meant the world to me.

Thank you to the national and international organizations that have supported me in my growth as a leader and writer, particularly the American Association of Critical-Care Nurses (AACN), the Association for Nurses in Professional Development (ANPD), the American Holistic Nurses Association (AHNA), the American Nurses Association (ANA), the National League for Nursing (NLN), and the Nightingale Initiative for Global Health (NIGH).

To my personal and creative inspirations, you have not only changed my views on the world of leadership but have touched my heart with your audacity, boldness, and truth. Brené Brown, thank you for daring greatly and teaching me the power of vulnerability as a person, professional, friend, family member, and leader; Elizabeth Gilbert, thank you for your words that have helped me to rediscover and celebrate my creativity and returned me to myself in my most challenging times; and Jacqueline Novogratz, thank you for your advocacy work in procuring human equality and dignity on a global scale and for inspiring me to live a life of immersion each and every day.

For my dear friends who have opened my heart and filled my life with joy. You know who you are. I love you.

In memory of my grandparents, Canio and Jennie Bartolini and William Rosa I, immigrant laborers who worked hard with minimal reward so that one day their grandchildren might be educated, find happiness, and write books.

My family, thank you for loving me, celebrating me, and for allowing me the privilege of loving you.

My brother, Kief, I am so happy you are in my life. Thank you for being a part of all of it.

Mom and Dad, words will fall short, regardless of what I try and say. Thank you for always being there.

My beautiful, loving, kind, and unbelievably caring husband, Michael, thank you for your unquestionable support throughout this project and in all I do. You are whole, perfect, and complete, and I love you just the way you are.
INTRODUCTION

Nurse as Leader:
A Journey of Privilege

William Rosa

The nurse belongs to the collective of nursing; we are all responsible for creating a community of compassionate, moral empathy that lifts the veil of silence and promotes healthy, respectful, clear and truthful articulation of our inner lives. . . . Nurses do not practice in silos. We all attend to the needs of humanity, and we all deserve to process this intimate, multi-faceted gift in environments of support [and] understanding (Rosa 2014a, p. 20). As nursing evolves . . . and procures [its] legacy, there is a sacred opportunity to merge the theoretical underpinnings of the profession with . . . [the] clinical realities. . . . It is in returning to the basics of our discipline that our dutiful complexities within the healthcare system will be understood, valued, and promoted (Rosa 2014b, p. 76).

■ LEADERSHIP AS PRIVILEGE

The essence of leadership, although considered one of the domains most discussed and written about in professional sectors the world over, often remains elusive in its application to practice. Leaders who innovate and implement an evolutionary vision of “how things could be” often personify concepts that we may tend to believe exist only in theory. But, somehow, they have figured it out—they have grasped that fine and delicate space of praxis, the congruence of theory in action.

Think of the most notable leaders in recent history and consider the words that come to mind in their wake: Mohandas K. Gandhi—truthful and nonviolent; Nelson Mandela—focused and determined; Martin Luther King Jr.—courageous and unwavering; Mother Teresa—compassionate and loving; Winston Churchill—confident and resolute. Now, the words listed to describe these individuals may differ from the ones you would use and may even seem to limit the depth of their persona and myriad
INTRODUCTION

contributions to humanity somewhat, but encapsulated in these words may very well be the vision they have left behind for all who follow. For example, Gandhi believed that through nonviolence, what is known as *ahimsa*, the truth of equality would be revealed and sociopolitical integrity would prevail in India. Mother Teresa showed the world that through demonstrable compassion and extending love toward those closest to each of us, we can change the world one person at a time. To these historical figures, leadership was a platform upon which they lived and practiced the precepts of social justice and human rights. For them, leadership was more than a power differential used to arouse notoriety. Leadership, for the Kings, Churchills, and Mandelas, will forever be a privilege—a life practice of wielding those ideals considered most sacred to the preservation and dignified existence of humanity.

It causes one to wonder, what are the words—the ideals, principles, and visions for a healthier world—that I will leave behind in my wake? What ethics do and can I employ, as a nurse, to positively impact another human being and, therefore, the world around me? What is the platform I hold and the privilege of leadership I possess in my daily practice, regardless of the setting? And, how do I begin to translate the concepts and ideas I have about leadership into practice, where who I am as a leader is received, felt, and understood for my good and the good of those I serve?

The literature is overwhelmed by scholarly contributions that attempt to define, delineate, and project the role of the nurse leader across specialties (Elwell & Elikofer, 2015; Plonien, 2015; Hart et al., 2014); differentiate between the types of leadership considered most effective (e.g., authentic, ethical, aesthetic; Mannix, Wilkes, & Daly, 2015; Spence Laschinger, Borgogni, Consiglio, & Read, 2015; Makaroff, Storch, Pauly, & Newton, 2014); promote a lens, program, or training through which leadership education can or should be imparted (Stikes, Arterberry, & Logsdon, 2015; Day et al., 2014); and question or inquire about leadership practices and discuss varied perceptions of leadership in nursing (Cutcliffe & Cleary, 2015).

None of these more traditional approaches to the ongoing dialogue on leadership are addressed in this book. This is not a training course and it is not an educational perspective. It is an offering. From this offering springs forth considerations and reflections, tools and options, interpretations and understandings, invitations and opportunities, and diverse paths and innovative aspirations. In this book, you hold the journeys of nurse change agents who have dealt with personal setbacks and tribulations, professional doubts and disappointments, and learned, through willingness and flexibility and self-honoring, how to elevate nursing to its place as a professional body of influence and major global leader in health care delivery and development. In fact, in this book you hold the ethos of what it means to be a nurse leader—the very essence of those who have laid the groundwork and those who continue to build the inroads of the discipline. In this book, you hold their stories, and in these stories, you hold the heart of nursing.

The misnomers may be more common than we would like to think: Bedside nurses who lack positions of authority or do not possess a lofty credential may continue to believe they are not leaders. The long-term impact they have on patients’ lives, and therefore the families, communities, and societies those patients are a part of, frequently goes unrealized. The bedside clinician’s abilities to coordinate the interdisciplinary care provided at any given time, to direct the flow and output of major health care facilities,
and to create environments of healing and preserve the dignity of another amid their suffering and health challenges, all the while maintaining and implementing exemplary clinical skills and knowledge, is nurse leader work. Nurse authors who contribute articles, letters, and poetry to publications may think they are not leading—but what thought patterns and professional trends are you exploring or challenging or expanding upon? Who will think differently after reading your words? That is nurse leader work. At times, teachers and instructors may be unable to fully comprehend the sphere of their influence beyond the time limitations of the term or the students who sit in front of them at any given moment, but this is the workforce of the next generation being trained to evolve and expand the minds and hearts who will advance nursing toward what it was always meant to be, and that is nurse leader work.

Nurse leader work is about who we are being and who we are aspiring to become. Nurse leader work is relational; it occurs at the interface of our individual ethics and how we show up to collaborate with others in partnership and service. Nurse leader work makes itself known through our words, behaviors, and actions, and reflects to others what is most important to us as people and as professionals. Leadership is an inherent aspect of being a nurse and so nurse leader work is always being done, consciously or unconsciously, knowingly or unknowingly. When we adopt the title “nurse,” we implicitly come to shoulder the responsibilities, ethical obligations, and privileges that comprise leadership. And the question is: What will we do with it?

AN EMERGING CONCEPT OF LEADERSHIP AS STARTING POINT

In order to more consciously engage the innate aspects of leadership within the nursing role and to have a premise with which to mature throughout the process of this book journey, a starting point lens is offered through which to think of leadership and how it is practiced. The Holistic Leadership Model (HLM) is “a participative leadership model in which people, regardless of formal titles, engage in a constructive process as equal partners to influence an affirming, sustainable, and humanistic outcome” (Andrus & Shanahan, 2016, p. 591). Holism is a cornerstone of the nursing profession, as suggested and discussed by Nightingale. Holistic nursing may be defined as “all nursing practice that has healing the whole person as its goal and honors relationship-centered care and the interconnectedness of self, others, nature, and spirituality” (Dossey, 2016, p. 3). One does not have to “become” a “holistic nurse” in order to utilize or apply this model to practice. In fact, given the definition in the preceding text, holistic nursing is a philosophy that can be embodied by multi-specialty clinicians, educators, administrators, policy advocates, teachers, or any role informed by the moral and ethical principles of nursing’s scope and standards. It is a way of being; a currency with which we practice the art and science of nursing. It can be used by bedside nurses in the emergency department and intensive care unit as easily as it can in outpatient psychiatry or advanced private practice, by the chief nursing officer and director of nursing research, as well as the unit manager and professional development specialist. It is a way of understanding and approaching one’s relationship with self and other, upon which other theories, skills, competencies, and personal ideals can be layered. The HLM is an inclusive worldview that invites all nurses, regardless of
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beliefs, preferences, or judgments, to partake in its emerging and ever-evolving concept of the nurse as leader.

This particular model is considered a synthesis of other participative leadership models, incorporating the idealized influence, inspiration and vision, intellectual stimulation, and individual consideration known as the core characteristics of transformational leadership (Burns, 1978); the principles of self-awareness, collaboration, and connection that Frisina (2011) discusses as central to influential leadership; and the emphasis of servant leadership on the primary desire to serve and be of service, the main focus of which is the growth and well-being of others (Greenleaf, 2002).

In order to make the HLM more relatable to nursing-specific considerations, several nursing professional practice models are used to help operationalize its theoretical perspectives and frameworks.

The BirchTree Center Model™ (Andrus & Shanahan, 2016; Shanahan, 2014; see Chapter 17 for more information on the BirchTree Center Model™ and Figure 17.1 for an illustration of its components)

• Serves as an integrative, interdisciplinary, progressive practice model of personal and professional transformation
• Promotes capacity building for individuals to develop a caring-healing ethic in transforming both personal practice and organizational culture
• Incorporates self-care, self-reflection, self-renewal, and self-awareness as essential to leadership competency
• Reorients shared values, behaviors, and actions of health care institutions toward healing and caring
• Links a cultural anchor of compassion to a standard of excellence for performance-based outcomes

The Quality Caring Model© (Duffy, 2009, 2015)

• Integrates the processes of caring with quality health care outcomes to promote nursing excellence
• Incudes structures involved in health care delivery: care providers, patients/family, and the health care organization/system
• Supports relationship-centered care informed by caring values, attitudes, and behaviors
• Focuses on improved interpersonal and clinical outcomes for the care provider and patient/family and economic, safety, and quality outcomes for the organization/system

The Caring in Nursing Administration Model (Nyburg, 1998)

• Promotes leadership actions that stem from an ethical core of the caring sciences
• Supports evidence-based caring research frameworks
• Requires nurse administrators to partake in and role model self-care and to extend that caring to create healing environments in organizations
• Identifies nurse administrators as leaders who have the potential to link the humanistic value of caring and the economic realities of health care to transform practice settings
The HLM includes all ways of knowing in the form of qualitative and quantitative research, narrative research inquiry, and appreciative inquiry (Andrus & Shanahan, 2016). In summary, the model:

- Recognizes that leaders working from this perspective will take on innovative roles in the transformation of health care
- Assumes that everyone is a leader, regardless of position or title
- Acknowledges that every nurse is a partner in the transformation of any given system

Additionally, the HLM identifies seven core characteristics of a holistic nurse leader that can be viewed along with brief explanations in Table I.1.

The HLM is just one perspective with which to more deeply engage the narratives of leadership and personal growth discussed in this text. It is a lens through which to remain open and available to the ideas and lived experiences of accomplished nurse leaders who share the vision of all nurses as cocreators in the future of the profession. It also serves as a canvas upon which to create and explore new ways of thinking about your own individual leadership capacities and potentials. It acts as a mirror while observing demonstrated leadership in the world, helping you to question if what you are seeing is representative of the highest good in nursing; aiding you to determine what you can do

**TABLE I.1 Core Characteristics of a Holistic Leader With Brief Descriptions**

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<tr>
<th>Core Characteristics of a Holistic Leader</th>
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<tr>
<td><strong>1. Visionary</strong></td>
<td>“Open to learning from other points of view through evolving the art of full presence, deep listening, and a nonjudgmental attitude . . . understands the deeper spiritual needs of people by caring for souls of individuals as well as the soul of the organization . . . see[s] the big picture and utiliz[es] out-of-the-box thinking” (p. 598)</td>
</tr>
<tr>
<td><strong>2. Inspirational presence</strong></td>
<td>“Inspires people to be their best selves through inclusion, respect, caring, and acknowledgment . . . foster[s] collaboration, teamwork, and shared information . . . embodies a sense of personal integrity that radiates to others as respect, kindness, and genuine, authentic caring” (pp. 598–599)</td>
</tr>
<tr>
<td><strong>3. Role model</strong></td>
<td>“Set[s] standards of excellence in clinical nursing . . . serve[s] as a positive example for other nurses to follow and emulate . . . There are four core principles that serve as pillars for role modeling: maintaining integrity, upholding ethical standards, demonstrating bold and courageous actions, and being visible-approachable-accessible” (p. 599)</td>
</tr>
<tr>
<td><strong>4. Mentor</strong></td>
<td>“View[s] mentorship as a mutually beneficial shared, rather than hierarchical, process where both people, as partners, learn and grow from one another’s insights and wisdom . . . allowing for acceptance, cooperation, appreciation, and inclusivity—a circle of influence” (p. 600)</td>
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(continued)
as a change agent—empowered with a vast array of leadership tools and perspectives—to better it. As the term holistic implies, we are integral to each other’s growth and experience of nurse leadership and interconnected in the healing of the collective, helping the profession move from the current-day status of professional fragmentation experienced at institutional, national, and international levels to a unified, singular, and powerful whole through shared and mutually beneficial leadership.

### EVOLUTIONARY LEADERSHIP ASSUMPTIONS

Several diverse and varying approaches are offered throughout this volume as possible paths to potentiating and realizing one’s inner and outer nurse leader. Contributing authors have found inspiration and direction through committing to higher education and participating in interdisciplinary collaborations, through adversity and hardships, and through opportunities for self-growth they never could have imagined. In preparing oneself for this writer–reader dialogue, there are several assumptions that may assist you in getting the most out of this experience. These assumptions in no way intend to create global statements or definitions on what leadership is and they do not account for all cross-cultural considerations or limitations some leaders may currently experience. They are simply suggestions that have been extrapolated from the themes expressed by the

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**TABLE I.1 Core Characteristics of a Holistic Leader With Brief Descriptions (continued)**

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<thead>
<tr>
<th>Core Characteristics of a Holistic Leader</th>
<th>Brief Description</th>
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<tr>
<td>5. Champion for clinical excellence</td>
<td>“[Links] the caring case of bedside care with the business case of healthcare transformation . . . promote[es] education and learning at every level . . . hold[s] nurses accountable for clinical excellence . . . intentional about . . . implementing progressive, innovative strategies . . . [and the] cultivation of true collaboration . . . elevate[s] the professionalism of nurses by encouraging . . . ongoing professional development and clinical competence” (pp. 600–601)</td>
</tr>
<tr>
<td>6. Courageous advocate</td>
<td>“Support[s] and enrich[es] all dimensions of . . . nursing practice, from bedside to boardroom . . . creat[es] a work environment and culture that fosters caring for nurses . . . [cultivates] [a]n innovative culture and workplace environment that enhances the patient experience and . . . satisfaction . . . build[s] . . . partnerships with community organizations . . . include[s] environmental health as a nurse competency” (pp. 601–603)</td>
</tr>
<tr>
<td>7. Cultural transformational agent</td>
<td>“Works to actualize a plan to transform the culture of an organization to become a caring, healing environment . . . supports nurse well-being, nurse-patient engagement, and a collaborative partnership among healthcare providers . . . create[s] avenues and opportunities for nurse empowerment . . . develops an infrastructure for an innovative, collaborative practice environment by providing structural empowerment” (p. 603)</td>
</tr>
</tbody>
</table>

As defined by Andrus and Shanahan (2016).
INTRODUCTION ■ 7

authors herein. The list is in no particular order of importance or relevance and is by no means exhaustive of idealistic leadership qualities. Rather, it is intended to support the reader in releasing self-imposed limitations that may abbreviate or negate the learning possibilities while reading and reflecting upon the wisdom of the following chapters. See Table I.2 for a list of these Evolutionary Leadership Assumptions (ELAs) followed by further explanation in the following text.

EVOLUTIONARY LEADERSHIP EMBRACES VULNERABILITY

Brown (2012) defines vulnerability as “uncertainty, risk, and emotional exposure” and acknowledges it as “the birthplace of love, belonging, joy, courage, empathy, and creativity . . . the source of hope . . ., accountability, and authenticity . . . [and the way to gain] greater clarity in our purpose . . . and more meaningful . . . lives” (p. 34). Brown (2012) writes that to “dare greatly” is to meet the fear of vulnerability head-on and to muster the strength to be our fully expressed selves in environments that do not give any guarantees. Ultimately, she goes on to say, “Vulnerability sounds like truth and feels like courage” (p. 37).

If a nurse is going to own and demonstrate behaviors representative of leadership, such as questioning the tasks presented, forming individual opinions, taking risks, relationship-building, showing excitement about work, creating adventure, providing something to believe in, and inspiring others (Taffinder, 2006), then learning to navigate and embrace vulnerability is essential. Having the courage to embrace and relate to one’s own vulnerability and that of another contributes to developing a compassionate practice and the ethical formation of nursing care (Thorup, Rundqvist, Roberts, & Delmar, 2012; Curtis, 2014). In fact, it has been noted that in environments where nurses’ vulnerability is acknowledged and their whole person is honored and celebrated, beyond the limitations of their technical skills and abilities, human flourishing for both nurses and those they care for is possible (Sumner, 2013). (See Chapter 27 for more information on the importance of deepening our understanding of vulnerability.)

<table>
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<tr>
<th>Evolutionary Leadership Assumptions</th>
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<tr>
<td>Evolutionary leadership embraces vulnerability.</td>
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<td>Evolutionary leadership calls for a state of openness and self-awareness.</td>
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<tr>
<td>Evolutionary leadership requires self-renewal and self-reflection.</td>
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<td>Evolutionary leadership implies a willingness to mature in ways of being, doing, thinking, seeing, and knowing.</td>
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<tr>
<td>Evolutionary leadership acknowledges the difference between striving and perfectionism.</td>
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<tr>
<td>Evolutionary leadership is “both/and” and not “either/or.”</td>
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<td>Evolutionary leadership respects all voices in the room.</td>
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<td>Evolutionary leaders rehumanize work environments to promote ethical engagement and meaningful partnerships.</td>
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<tr>
<td>Evolutionary leaders work to unveil and promote the truth.</td>
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<tr>
<td>Evolutionary leaders allow for the transformation of self and systems.</td>
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INTRODUCTION

EVOLUTIONARY LEADERSHIP CALLS FOR A STATE OF OPENNESS AND SELF-AWARENESS

As a leader, as one whose actions will impact those around him or her either through influence or direct action, it is vital to maintain an attitude of openness. Openness requires suspending preconceived judgments and being willing to see things from another’s point of view. It can also be thought of as “coming from nothing” or surrendering the automatic labels and meanings we tend to place on anything and everything that hinder our abilities to grow and consider life from a different perspective (DiMaggio, 2011a). “The nothing that’s available for us to experience is not nothing as a negation of self . . . [but the ability] to create, design, and live with a freedom that’s not available when we create from something . . . a clearing that frees [us] from [our] own self-imposed restrictions” (DiMaggio, 2011a, p. 18).

We can also think of the application of openness as the concept of the beginner’s mind in Zen practice (Suzuki, 1983), or unknowing, releasing previously held beliefs as a way of experiencing a phenomenon in nursing practice (Munhall, 1993). Coming from nothing, employing a beginner’s mind, and applying unknowing are all forms of openness that allow for a clean slate in the teaching–learning process and create space for new possibilities to emerge that are inaccessible when coming from something, employing an expert’s lens, and honoring previously held knowing as fact.

Maturing in self-awareness and taking action to improve upon observed growth opportunities increases the nurse’s capacity to provide caring and healing to self and others (Thornton & Mariano, 2016). As it pertains to the learning process and the work milieu, self-awareness can alert us when we are attaching to outdated beliefs and patterns that prevent us from being open and available to the concepts presented. Self-awareness may assist you in identifying and acknowledging those areas where you are resistant to growth and evolution, and may also engender the willingness necessary to surrender those self-imposed limitations that no longer serve you. (See Chapter 9 for more on how openness and self-awareness facilitate healing in nursing.)

EVOLUTIONARY LEADERSHIP REQUIRES SELF-RENEWAL AND SELF-REFLECTION

Nurse leaders “reflect on action to become aware of values, feelings, perceptions, and judgments that may affect actions, and they also reflect on their experiences to obtain insight for future practice” (Mariano, 2016, p. 66). These reflections are just one component of the self-renewal work needed to meet the anticipated demands of effective leadership. This ELA is deeply related to increasing self-awareness and helping one to remain open to what is available in the moment, as mentioned above, but maintains further implications in the development and application of leadership-based ethics. While the questions offered at the end of each chapter provide one avenue for ongoing and progressive introspection, self-renewal and self-reflection work can also take the form of journaling, storytelling, meditation, creative expression, and other mindfulness practices. These outlets allow the nurse leader to process the events and people around him or her, reframe experiences from a different perspective, reconnect and recommit to inner purpose and intention, and come to know the self at a deeper level. Quite simply: “Reflection is a...
means of renewal” (Pesut, 2005, p.1). Responsibility for self-renewal is necessary for the individual mental, emotional, and spiritual well-being of nurses who are committed to the delivery of humane, quality care (Pesut, 2012). Reflective practice, while shown to improve individual performance outcomes, can also elevate organizational consciousness when applied at a systems level (Sherwood & Horton-Deutsch, 2012, 2015).

**EVOLUTIONARY LEADERSHIP IMPLIES A WILLINGNESS TO MATURE IN WAYS OF BEING, DOING, THINKING, SEEING, AND KNOWING**

Willingness suggests one who is flexible and adaptive, tolerant and mindful, in touch with one’s inner wisdom, and appreciative and stable in one’s sense of self (Schaub & Schaub, 1997). All ways of being, doing, thinking, seeing, and knowing are invited to expand and mature throughout this book journey. It is not a task you are asked to complete. Rather, it is an offering that implores you to acknowledge and personalize that which is beneficial to your journey as a nurse leader from the wealth of the authors’ lived experiences. As you read and reflect upon the histories of these nurse leaders, continue to ask yourself important questions such as, Who am I being? Does that way of being support me in realizing my highest potential as a nurse leader? Would doing things in a new way contribute toward the betterment of myself or another? How can I think about my leadership from a different vantage point? Would it benefit me to release what I know in order to relearn and reconsider? Leadership becomes stagnant without a willingness to unravel previously held, long-standing beliefs and emerge into a way of being-doing-thinking-seeing-knowing you may never have considered before. (See Chapters 13 and 30 for more on new ways of engaging the world.)

**EVOLUTIONARY LEADERSHIP ACKNOWLEDGES THE DIFFERENCE BETWEEN STRIVING AND PERFECTIONISM**

Brown (2010) states that the quest for perfectionism is very different from healthy striving and a desire to be one’s best:

Perfectionism is *not* about healthy achievement and growth. Perfectionism is the belief that if we live perfect, . . . we can minimize or avoid the pain of blame, judgment, and shame. . . . Perfectionism is *not* self-improvement. . . . Healthy striving is self-focused—*How can I improve?* Perfectionism is other-focused—*What will they think?* (pp. 94–95)

Healthy striving keeps our contributions as unique individuals and our journeys of self-growth, self-realization, and self-expression rooted in personal integrity. The process of striving helps us to understand that leadership is not about perfection and that the idea of perfect outcomes of any kind is a drain on our energy and interpersonal resources. In fact, the nurse leader who can acknowledge mistakes, ask for help, take risks, and share creative ideas without fear of others’ judgments or opinions is living authentically (Brown, 2012). Striving is an inherent aspect of the human experience (Watson, 2012), the quest to become more evolved and grounded in who we are, the unyielding motivation to improve upon
INTRODUCTION

ourselves mentally, emotionally, and spiritually, and the desire to reconnect with our inner and highest wisdom. Striving calls for the authentic integration of the personal and professional: in other words, fostering the integrity of a unified self. Inversely, the path of perfectionism further compartmentalizes how we see ourselves, our lives, and our contributions. It is in our commitment to healthy striving and releasing the need for perfectionism that we find the freedom to embrace our individualism as nurse leaders (See Chapters 28 and 29 for more on merging the personal and professional for a healthy and unified self.)

EVOLUTIONARY LEADERSHIP IS “BOTH/AND” AND NOT “EITHER/OR”

There is no need for inner fragmentation: for a mental–emotional separation of our personal–professional life, as previously noted, or for the self-limitations that keep us from experiencing a reality of inclusivity. Nurse leaders do not have to choose between leadership methodologies: between being holistic or not, incorporating nurse theories or not, believing in caring as the essence of nursing or not. Leadership is an adventure into “both/and.” As an intelligent and accountable nurse leader, you have the opportunity to select the concepts, ideas, and inquiries that will support you in becoming an effective force for positive change, as you are, with what you have to contribute at this point in time. Pressuring ourselves to choose between “either/or” diminishes the integrity of our innate human complexities and creates barriers to our wholeness. Living an undivided life and reading the pages that follow from a perspective of “both/and” can help one in learning how to shape an integral experience, derive meaning and value in community, teach and learn for transformation, and understand how to influence valuable and peaceful social change (Palmer, 2004). (See Chapter 4 for more on integral leadership and wholeness.)

EVOLUTIONARY LEADERSHIP RESPECTS ALL VOICES IN THE ROOM

Provision 1 of the American Nurses Association’s (ANA, 2015) Code of Ethics for Nurses With Interpretive Statements is clear that “the nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (p. 1). Attention to this provision ensures that human dignity is preserved in all interactions and that people feel heard and acknowledged. As you read, you may see statements or opinions you disagree with or doubt. Feel free to reflect upon any resistance you encounter, but do your best to respect each chapter as an expression of an author’s lived experience and as what the author knows to be true. Consider the context from which the insight was offered, glean what you can, and remain open to what it can teach you.

Provision 5 of the ANA (2015) Code of Ethics states that “the nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth” (p. 19). This means that self-respect is integral to this journey of learning and expansion. Strive to cultivate self-respect as you challenge yourself, explore new perspectives, and engage in self-development. (See Chapter 21 for more on the power of caring collaboration and leading from beside.)
INTRODUCTION

EVOLUTIONARY LEADERS REHUMANIZE WORK ENVIRONMENTS TO PROMOTE ETHICAL ENGAGEMENT AND MEANINGFUL PARTNERSHIPS

Leaders and those they partner with thrive in environments where creativity is valued, vulnerabilities are embraced, and people are respected for who they are and what they bring to the table. Brown (2012) points out in the “Daring Greatly Leadership Manifesto”:

When learning and working are dehumanized—when you no longer see us and encourage our daring, or when you only see what we produce or how we perform—we disengage and turn away from the very things the world needs from us: our talent, our ideas, and our passion. (p. 212)

It is no secret that many health care environments have become dehumanized by succumbing to bureaucratic dictates (Watson, 2005, 2008) that focus on employee output, patient outcomes, insurance reimbursement, regulatory standards, and the adage, “Do more with less.” Nursing has witnessed the submergence of its humanistic core values—its own dehumanization of value and purpose (Watson, 2012).

This fact is not something to resist or resent but something to acknowledge in one’s evolving nurse leader journey. The business of health care is a reality that must be considered and included in nurse leadership dialogue at this time. All nurses need to be educated to understand and respect the places and spaces where business and nursing merge. The altruistic ethics of nursing are vital for the preservation of dignity wherever it is threatened, but empathy is only our starting point. It must be combined with focus and conviction, the toughness to know what needs to get done and the courage to follow through . . . We will only succeed if we fuse a very hardheaded analysis with an equally soft heart. (Novogratz, 2009, p. 284)

In rehumanizing our learning experience, in coming to value both the experiential wisdom of others and our own individual uniqueness, we create new possibilities for our understanding of both nursing and leadership. (See Chapters 16, 19, and 23 for more on rehumanizing health care on a global scale.)

EVOLUTIONARY LEADERS WORK TO UNVEIL AND PROMOTE THE TRUTH

When nurses are taught how to complete a thorough pain assessment, they are reminded about the subjective truth of the patient: “Pain is whatever the patient says it is.” It is with the same nonjudgmental and available approach that the nurse leader seeks out the subjective truth of the populations and communities they serve. Ethical commitments to beneficence and social justice guide our leadership on a truth-seeking journey to ensure the equitable access to and delivery of services. It is this mission to engage, acknowledge, and understand the truth of another that allows the nurse leader to be sure he or she is acting from a place of moral and ethical integrity. Quality, dignified health care is a human right and it is the nurse leader’s role to honor and procure this truth. (See Chapters 5 and 11 for more on the role of nurse leaders in promoting truth through beneficence and social justice.)
12 ■ INTRODUCTION

EVOLUTIONARY LEADERS ALLOW FOR THE TRANSFORMATION OF SELF AND SYSTEMS

Transformation may be simply defined herein as allowing for the positive and reflective growth of self so that we are never the same. It is a bold action—a commitment to learning new ways of interacting with the surrounding world, exploring previously untapped parts of ourselves, and teaching-learning-role modeling with consideration to “what is” while believing in “what could be.”

Transformation has the power to upset the status quo, to unseat us from business as usual—it gives us a platform for being all we can . . . to live consistent with what we know is possible . . . . Transformation carries with it . . . a knowing that we have a choice about who we are. (Dimaggio, 2011b, p. 49)

Transformation of self and systems go hand-in-hand. As individuals transform how they engage with health care, the infrastructures they create and sustain will come to reflect their heightened ethics and values. Individual transformation on a mass scale advances systems toward the ideals of a caring society (See Chapters 17 and 26 for more on the transformation of self and systems.)

■ ONWARD

While reading the words and life lessons of the leaders presented here, allow your understandings of nursing and health and well-being and leadership to shift, expand, and mature into something beyond your current understanding. Release the need to control the experience and give yourself permission to remain vulnerable, open, and self-aware in the process; maintain your willingness to redefine how and who you are; observe your need for perfection and recommit to healthy striving; be inclusive and undivided in your journey; respect all voices and perspectives for what they offer; rehumanize the learning experience through an honoring of creativity, expression, and passion; and seek to unveil and promote your own truth. Transformation of self in this context allows one to embrace the current status of health care and the nursing profession with hope for positive and mutually beneficial change, guided and supported by an individually constructed, evolutionary vision of leadership.

The HLM and ELAs provide a framework and foundation from which to explore your personal understandings, expressions, and commitments to yourself as a nurse leader. Now is the time to put the theory into action to create new possibilities for yourself and those you are leading and will lead. I leave you to continue your journey with the inspired and powerful words of global citizen entrepreneur, author, change agent, and leader, Jacqueline Novogratz (2009):

Every one of us . . . has something important to give. . . . Build a vision for the people and recognize that no single source of leadership will make it happen. . . . We have only one world . . . and the future really is ours to create, in a world we dare to imagine together. (pp. 281, 283–284)
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Brown, B. (2010). *The gifts of imperfections: Letting go of who we think we should be and embracing who we are*. Center City, MN: Hazelden.


INTRODUCTION


PART I

Laying the Groundwork
CHAPTER ONE

Mindful and Intentional: Embodying Interbeing Awareness in Grassroots Leadership

Jeanne Anselmo

We touch dimensions of the sacred each day in nursing. Understanding how spirit and our sense of interconnectedness, meaning, and purpose impact our health and life continuously offers us new opportunities for growth, renewal, deepening, and learning. Whether we are new nurses or experienced practitioners, the journey continues to unfold.

—Anselmo and O’Brien (2013, p. 226)

WHY NURSING?

I would like to begin by offering a meditation practice, the first of three kitchen-table wisdoms found in this chapter. If you like, you can do this practice along with me as you read this. Thich Nhat Hanh, also known as Thay, taught me this practice in the early 1990s in the kitchen of a prewar building on the Upper West Side of Manhattan. It was late afternoon and Thay was seated at a small table covered with a blue-and-white checkered oilcloth as a few of us drank small cups of tea. We had all been sitting quietly together when Thay slowly raised his right hand in the air above his head and began to glide it vertically downward in front of him and shared something like, “All the ancestors of the spiritual and blood families who have gone before us.” Pausing at an imaginary midpoint for just an instant, he then continued his hand’s gentle movement downward, “And all those descendants yet to be born.” He then moved his hand to the far left and moved it across his body to the right on an invisible horizontal axis, “And all people and all species alive in the world in this moment.” He then raised his hand once again above his head and began drawing a circle in the air around the invisible horizontal and vertical...
axes as if his hand were a great brush, offering, “I let go of the idea that I am this body and my life span is limited” (Nhat Hanh, 2007, p. 48).

The practice Thich Nhat Hanh shared with us that afternoon touched a deep truth, a truth that I knew from my own inner experience. That is, each of our lives has arisen from an interconnected web of ancestors, nature, and life, and the gifts we offer the world have also arisen from both what we have inherited and what we have cultivated. As nurses and as leaders, we each have a great inheritance of love, wisdom, compassion, skillfulness, and awareness that comes from nursing, our families, and our spiritual and land ancestors. Knowing our multirooted map anchors us in a great mystery that supports and guides our lives and practice of nursing in ways beyond our own efforts and awareness.

I am aware that this year marks my 40th anniversary as a nurse. For these past decades, nursing is and has been a path of personal and professional self-development and spiritual discovery, an awakening to self, compassion, life’s mystery, and our interconnectedness (what I now call Interbeing). In many ways, I take no credit for what has unfolded along this path. I say this not with any self-deprecation, for I acknowledge the deep intention, study, and effort I have invested in my life and this nursing path and have done so with real heart and commitment. But shared in the meditation in the preceding text, along with my own efforts and presence, are the gifts and challenges of those who have gone before, those who will come after, and all beings, whether animal, plant, mineral, or human, alive in the here and now. For each of us, all these dimensions come together, composing a life, composing a path, offering a life message, a life teaching. Every nurse has the capacity to embody her or his gifts and offer them to life, to those we serve: our patients, families, and communities. In this way, every nurse is a leader, offering a life teaching through her or his embodied study and practice of nursing, paraphrasing what Thich Nhat Hanh shares, and Gandhi before him: “Our life is our message.” So in this spirit, I offer a few pivotal awareness moments still alive in my heart that embody this nurse’s life message and path of nursing. I offer these in the hope that you can touch the wisdom and wonder in yourself.

I would never have imagined that as a first-year new nursing student, listening to Dean Eleanor Lambertsen’s orientation welcome to us as the incoming class of 1975 at Cornell New York Hospital School of Nursing, I would experience a moment of awakening. And yet I did. Her talk focused on what lay ahead for us as we embarked on our path to becoming a nurse. As I listened, something opened in me as clarity, a larger sense of self, of life, and a deeper and greater experience of nursing. In that moment, I experienced nursing as a great vehicle to support human beings embody being truly alive, fully human, and humane. I became aware that for this vision to unfold, nursing’s gifts would have to be deeply embedded and embodied within humanity in all forms, beyond what was known as nursing in 1973. It also became clear that many of my previous life experiences had led me to this moment of listening to this orientation. This made becoming a nurse a real calling that had been evolving all my life, even from before I was born. Both sides of my family were immigrants to this country, carrying with them deep spiritual Catholic roots, Irish on my mother’s side and Sicilian on my father’s, so healing, community, service, connection to nature, and spirituality were just natural elements of my life growing up. Though both of my parents’ lives included what many immigrants experienced—poverty, illness, early death of loved ones, and discrimination—they also carried personal true spiritual aspiration, love, connection to family, community, nature, and strong faith.
My mother's deeply devotional prayer life opened doors for me to St. Theresa of Avila, St. Therese (The Little Flower), St. Francis of Assisi, and Thomas Merton; my father's spiritual life brought me many devotional blessings, play, and the positive vision of Dr. Norman Vincent Peale. Mom's family were farmers, intuitive dreamers, and horse whisperers in Ireland, and district nurses and handy women in northern England, and they all knew herbal and natural remedies to care for illnesses. My father and his brothers learned natural remedies working in their uncle's pharmacy in the Hell's Kitchen section of Manhattan during the early 20th century. For both sides of my family, healing was local and natural, providing health care for the poor, whether through the village handy women, like my mother's Aunt Alice, or English district nurses, like her cousin Rose, or pharmacists, like my great-uncle Peter of Anselmo's Pharmacy. In poor mill and mining villages, handy women “took the place of doctors (who were few) and prepared poultices, salts, herbs, and offered nursing care” (M.D. Anselmo, personal communication, 1989). Great-uncle Peter was known to treat whoever needed care, regardless of their ability to pay. His inspiration led to a number of his nephews (my uncles) following in his footsteps, becoming pharmacists themselves and studying at St. John's University School of Pharmacy. In the 1990s and 2000s, I had a family full-circle continuation experience when the faculty of St. John's School of Pharmacy, the same school my father's brothers attended, invited me to teach the current pharmacy students about holistic nonpharmacological approaches to healing.

Entering nursing school, I was not truly aware of how much my family members' gifts and efforts had guided me toward not only becoming a nurse, but also becoming a holistic nurse focused on natural approaches to healing, especially for the disadvantaged. As a student, I also was unaware of the true impact Cornell's faculty would have, as they introduced me to Dr. Martha Rogers's little-known Science of Unitary Human Beings, which offered a new revolutionary quantum-based theory in nursing. Many of Cornell's faculty members were students of both Dr. Rogers and Dr. Delores (Dee) Krieger at New York University's (NYU's) graduate nursing program. In the fall of 1973, we students would soon be struggling to comprehend Rogers's new paradigm and reflect on Dee Krieger and Dora Kunz's therapeutic touch, a practice of Renaissance Nursing (Krieger, 1981).

Cornell's Dean Lambertsen had a commitment to cultivating nursing leadership for a new revolutionary era of wellness health care, so its nursing program focused on the profession as a path of lifelong study, evolution, and continuous learning. Cornell developed a progressive, yet controversial, curriculum offering more nursing science classroom hours and fewer hospital-based clinical hours, the backbone of most other programs at the time. This radical departure from standard nursing education supported our capacities for developing innovative practice but became a source of criticism in some circles for both Cornell's program and its graduates. Dean Lambertsen was a woman of great vision and determination.

She pioneered the concept of “team nursing,” revolutionizing the organization and delivery of nursing and health care by placing registered professional nurses in the primary interdisciplinary leadership role. . . .

Her influence made it possible for generations of clinical nurse specialists and nurse practitioners to practice their art and science independently. (American Nurses Association [ANA], 2012)
During the 1970 senior convocation, then newly appointed Dean Lambertsen spoke of “nurses capable of developing innovative patterns of patient care while others practiced within the framework of the existing structure” (Fondiller, 2007, p. 185). Truly, the program at Cornell gave me a foundation for adapting to changes in health care and developing new and innovative approaches, not only within nursing but also within holistic nursing, applied psychophysiology, and biofeedback, and later within social justice and public interest lawyering.

The spirit and vision of celebrated alumna, community health innovator, and women’s rights activist Lillian Wald was also a very active dimension of our education at Cornell, as all students served as community health nurses at Wald’s Visiting Nurse Services of New York (VNSNY), founded in 1891. Wald’s commitment to social reform and improving the quality of life for the poor and disadvantaged was reflected at VNSNY and at Henry Street Settlement founded in 1893. Wald told her nurses: “Nursing is love in action, and there is no finer manifestation of it than the care of the poor and disabled in their own homes” (Lundy & Bender, 2016, p. 90). Wald’s vision of nursing as “love in action” not only guided my own practice working in the community and underserved areas, but also surfaced decades later in a new form when I was invited to teach young social justice law students. I shared that I saw them as healers, building beloved communities, and they responded with echoes of Lillian Wald, asking me to teach them “law based in love.”

All these elements of the past, present, and possible future were woven into that first awakening that I experienced during orientation in 1973. It was a reorienting of my heart, a fresh understanding and perspective of nursing as a spiritual path of practice, which continues within me today. From that moment on, my inner compass became activated within my nursing study and practice. This did not mean that I did not experience disappointments, challenges, and frustrations that were a part of nursing, especially during the 1970s, when nursing was far from being positively valued (not only by some men, but also by some progressive women of the day). But from then on, my path as a nurse was connected to an inner awareness that has continued to unfold and guide me beyond what may be visible and clear. This inner guidance has offered a path I could never have imagined. The links and connections that have led me along this path may seem in some ways obvious now, but were not obvious or clear to me then.

■ EARLY IMPRESSIONS

As a student nurse, I had the opportunity to learn a great lesson as I cared for a first-time young mother during my labor and delivery clinical rotation. “Sarah” was having a difficult labor and though I had yet to learn therapeutic touch, I discovered, as I was breathing with her and massaging her back, that a deeper connection unfolded between the two of us, so much so that my hands seemed to know exactly where to go. Everything became flow. I realized that Sarah and I had touched a true communion in the nurse–patient relationship, but that this was not able to be supported by the staff nurses on the floor, though they were doing their best. At the end of my shift, my instructor had me leave even though Sarah pleaded that I be allowed to stay. We both had been touched by the deep connection we shared and I saw the beauty and healing potential of cultivating
a nurse–patient relationship akin to what doulas or midwives offer for all clients/patients; for some time thereafter, I strongly considered becoming a nurse midwife.

Years later, I established a community-based holistic nursing private practice in my hometown, in which I midwifed the deathing of a small number of clients who had cancer or AIDS. Doing so, I was able to travel with them and their families through their healing journey of illness and end-of-life experience (Hostutler, Kennedy, Mason, & Schorr, 2000). This healing relationship with my clients became a key dimension of my private practice and required a deeper self-awareness and more profound level of personal and professional self-care, which included personal retreats. These seeds for midwifing within my professional practice may have been sown in me through my great-aunt Alice, the handy woman delivering babies on Puddlers Row in North England, and through caring for Sarah as a student.

Upon graduation, I chose to work at Memorial Sloan Kettering Cancer Center (MSKCC), as it would take me “into the fire” of my own growing edge, allowing me the opportunity to be with life-challenging illness, face fears, and be with death and dying. In 1975, working at MSKCC was considered high risk, as the incidence of cancer among MSKCC staff was far greater than at any other institution, so there was a belief, at that time, that cancer was contagious. This risk did not factor into my decision; my inner guidance did. Working at MSKCC opened me to deep teachings of the heart and offered many opportunities for cultivating equanimity (nondiscrimination or inclusiveness).

A very meaningful experience of equanimity unfolded as I was assigned both an elderly Holocaust survivor and a young male from Argentina, who was the child of a former Nazi soldier. Both had cancer and both became teachers of my heart as I served, supported, and cared for them. Though they did not know each other, together they opened my heart to a deeper calling and understanding of nursing: the gifts of compassion, going beyond all concepts of discrimination, views of right and wrong, touching our shared humanity, and cultivating true openhearted inclusiveness within ourselves. Once begun, this inclusive opening, expanding process of the heart has continued to guide my study and practice of moving beyond discrimination and the boundaries of nonduality.

I continued to work with people living with cancer and AIDS for the next 25 years and learned through lived experience that

Nurses have access to clients in their most vulnerable . . . moments—the birth of a child, the moment of death, and the . . . joys, and fears of life. Many times we are the spiritual support that holds the hand, witnesses the first . . . or the last breath, and offers solace and understanding. (Anselmo & O’Brien, 2013, p. 239)

Through this work, I found that the same levels of love and attention were required for both illness and wellness care, including the wellness self-care needed to sustain oneself as a nurse. In fact, I realized it was essential to integrate wellness for all into every form of health care, especially during end-of-life practice. Walking in the last moments and
breaths of life with my patients opened me to experience a greater connection to all that is, the birthless/deathless consciousness that continues, whether we are in bodily form or not.

After leaving MSKCC in 1976, I was hired as a nurse biofeedback and stress management therapist at an executive health clinic in Manhattan. The position offered the autonomy of the nursing private practice Lambertsen envisioned, while offering the wellness-based, nonpharmacological holistic interventions of biofeedback and relaxation embedded with the health care teaching and counseling that Krieger and Rogers espoused. Most biofeedback practitioners of the time were not nurses, so my inclusion of health care teaching, counseling, and hands-on healing, combined with my comfort level with experimental protocols after working at MSKCC, offered unique nursing dimensions and contributions to biofeedback professional practice.

In the 1970s, it was not widely accepted that the psychophysiology of mind and body (let alone mind, body, and spirit) were interconnected and influenced each other. Therefore, I was fiercely challenged as I taught at biofeedback workshops to researchers, neurologists, psychiatrists, and psychologists, who seemed appalled that a young nurse was attempting to teach them something that flew in the face of all they had studied and believed as scientific fact. Rather than trying to convince them that mind and emotions influenced physiological responses, I offered them the opportunity to experience biofeedback themselves and let their own experience provide their answer. The unbiased technology registered a psychophysiological response reflecting their cognitive or emotional states and, most times, opened them to the possibility of a new understanding of themselves and psychophysiology: body, mind, and emotion connectedness.

I have continued to offer this practice as an experiment for nurses developing body-mind-spirit self-awareness (Anselmo, 2016). Biofeedback was also a method for tracking psychophysiological responses to therapeutic touch by NYU graduate nurse researchers. In 1979, I was invited to join Janet Macrae, Marie Therese Connell Meehan, and Patricia Heidt as core faculty of NYU’s postgraduate, yearlong Integrative Nursing Certificate Program, which hosted many of the nursing pioneers found in Dee Krieger’s 1981 book Renaissance Nursing.

Graduates from that program continued to embrace a nursing pioneering spirit and practice over the ensuing decades and became innovative leaders themselves. I felt humbled and grateful to have the opportunity to study, share practice, and teach with these nursing visionaries, whether students or faculty. Among this rich tapestry of nursing heart paths, Marie Therese Connell offered us her definition of nursing at the time: “Nursing is tending the flow of Life.” Tending the flow of life spoke deeply to a larger communion and commitment that nursing has with life. Her words echoed Nightingale’s deep resonance with nature, our communion with this planet, and all our relations. Being with the flow of life, practicing healing and therapeutic touch, working with patients, and reflecting on myself led me to naturally change my diet and lifestyle, explore spiritual practices and study healing, energy practices, and oneness/interconnectedness with Native Americans, Chi Kung masters, and Armenian healers. All these teachers embodied this communion and connection with life, sharing nondual wisdom, what some call “Big Sky Mind” or “All That Is.”

As I went deeper into studying healing, my work evolved and I began to be called to work in community health projects in underserved communities, consult in larger organizations and corporations, and serve in leadership positions. While working in
these projects, the vital importance of community, especially addressing larger systems challenges, became even more evident. A vision of beloved community, in which every member is also a leader/healer, arose within me and I then viewed and experienced each community as a spiritual community, whether they did so themselves or not. Bringing this spiritual dimension into the community’s and my own mutual awareness elevated our work together and offered new collective potentials beyond what seemed available or possible at the time.

In 1989, I was elected the first nurse and first woman president of the Biofeedback Society of New York State. It marked a turning point in the organization’s history, for even though biofeedback was founded on interdisciplinary principles, practice, understanding, collaboration, and insight (all of which had been very inspirational and resonant with my own values and vision), neither its board members nor the actual workings of the organization, like many at that time, reflected such an enlightened view. One of my goals as president was to actualize the true interdisciplinary potential professional biofeedback held. So, over the next few years, and not without great challenges and resistance, the organization became more inclusive, reflecting the professionals, healers, and educators who made up this unique and diverse community, as well as beginning a multiyear expansion from a state to a regional organization. This vision continues to be lived today.

In late 1989, Susan Luck (see Chapter 24) and I met at her East Village apartment where, at her kitchen table, we began to weave together the first threads of Holistic Nursing Associates for teaching and mentoring nurses interested in healing and transforming themselves and their practice. Susan knew Bonney Schaub (see Chapter 27), a nurse psychosynthesis practitioner, who we invited to join this new initiative. Together, the three of us wove together our knowledge, experience, and practice offering a continuing education certificate program called Caring for Ourselves, Caring for Others: The Holistic Nursing Process. Our goals were to support nurses to reconnect with their roots, values, and inspirations that first brought them to nursing, learn holistic self-care, develop professional holistic nursing patient care practices, and pioneer new paths for both living and implementing these practices, all within an unfolding, safe, and supportive nursing community. For 10 years, nurses found their way to us in the West Village and began their own journey of personal and professional transformation. What arose within these participants was truly inspiring for us all and, at times, offered stunning transformations, as some were impelled to leave jobs and personal relationships no longer serving them and began to journey into their own personal and professional unknown, while others found renewal for reentering their work, relationships, and roles, imbuing them with new vision, compassion, and practice skills.

In the mid-1990s, a small grassroots movement in the Northeast arose to address a nationwide challenge to the profession of nursing. Begun as a reorganization of health care, it included downsizing and reengineering of hospitals, massive nursing layoffs, and a campaign to replace licensed RNs with less-costly hospital-trained technicians. Local nurses were understandably caught by the fear generated by this crisis, and at one local nursing conference, I was asked to offer stress management to help address this challenge. I realized that what was being called for was more than stress management, which could possibly mask what was happening. This was nursing’s health challenge/life-threatening illness, as we faced our own uncertain future, both individually and collectively.
At the time, it was unclear if nursing, as a profession, would survive, so walking into this unknown, unclear, and uncertain future, I saw this challenge as an invitation for personal and collective reflection, whether this was truly the end of our profession or not. Along with stress reduction, I invited reflection on the following: How would we want our collective/profession to spend these precious days together during this great challenge? What healing would we want to offer ourselves and each other, and model for the world? As I contemplated these questions myself, a cognition arose that we needed a way to apply our collective gifts and insights as well as embrace and be with the pain, fear, loss, and challenge unfolding.

To explore these questions, a “kitchen cabinet” of friends and colleagues gathered in Soho around Barbara Glickstein’s kitchen table, including Barbara, Diana Mason (see Endnote), Barbara Joyce (then New York State Nurses Association’s [NYSNA’s] president), and myself. Together we crafted a grassroots nursing movement, which continued for the next five years. Holding nursing town meetings, we offered inspiration, time for sharing, meditation, and reflection, while updating nurses with reliable information from NYSNA regarding the crisis and encouraged the creation of healing circles so nurses had continuing local support. These simple approaches helped build community, reduce fear of the unknown, and reduce the chaos generated by the continuous unexpected layoffs and a dearth of communication from administration to staff nurses and managers.

As the crisis continued to mount, we realized that we needed to expand our efforts by reaching out regionally to as many nursing organizations as possible. Gathering a diverse group of nurse leaders who represented local and national nursing organizations, we planned a regional nursing summit. Our monthly planning meetings, truly, were the living summit process we aspired to for our community as we shared our hearts, cultivated our intention to heal our personal and collective fears, and grieved the loss of our colleagues and the failing health care system in which we had attempted to sustain quality patient care. As we dialogued, we realized that we needed to present possibilities for the future, so we invited innovators from across the country, including our friends and colleagues at the University of Minnesota, Mary Jo Kreitzer (see Chapter 8), Sue Towey, Joanne Disch, and Barbara Dossey of Holistic Nursing Consultants (see Chapter 4), to share their visionary initiatives. These initiatives offered inspiration and an alternative to solely being angry, numb, in denial, or paralyzed by fear. Guided by Native American council circle wisdom, our intention was to gather, share our collective wisdom, learn from each other, and heal together so we could return to our lives and “dance with the chaos.” Nurses were invited to enter the summit heart-to-heart, nurse-to-nurse, leaving roles, positions, titles, and credentials at the door. To support and grow grassroots nursing leadership, we attempted to turn expectations upside down by mentoring staff nurses and students to be facilitators at the summit rather than turning to the innumerable, highly skilled leaders attending. These grassroots nurses, who did not see themselves as leaders, facilitated sharing circles, which included national/international nurse leaders, thereby offering real-life leadership experience and building their self-confidence.

Our first regional summit was held at Omega in 1997, followed by another in 1998, mirroring the same yearlong presummit process, but this time its focus was diversity and community. To emphasize our deep and true commitment to explore our society’s most challenging and important issues, we opened the second summit with a joint welcome by nurses of color and those not of color introducing a video of Lani Guinier
speaking about race as society’s “canary in a coalmine” and the importance of grassroots/bottom-up change (Guinier, 1998). Many nurses attending were moved to tears by our collective’s willingness and openness to look into issues of race and racism from the very inception of our gathering. Both summits were committed to healing the wounds in ourselves, our profession, and relationships with and between each other, as a foundation for taking on the systemic challenges unfolding. They offered inspiration, community, connection, and innovation in a time of real crisis. Our collective efforts culminated in a presentation by members of the summit community at the 100th Anniversary London Conference of the International Council of Nurses in 1999. In many respects, the vision and contributions of this book are a continuation of this movement, for many contributors found in this book were a vital part of these summits.

In 2000, Rachel Gluckstein—a friend, colleague, and gifted nurse yoga and shiatsu teacher/practitioner working in community health and private practice—and I both received calls from Fred Rooney, founding director of the Community Legal Resource Network (CLRN) at the City University of New York (CUNY) School of Law. Fred wanted to provide law graduates yoga and meditation techniques to assuage the mounting drug self-medication and alcohol abuse and in order to relieve the painful realities and stresses found in social justice law practice. CUNY was one of the most diverse law schools in the country, drawing to its program nontraditional law students from underserved communities from across the country and around the world. These graduates then planned to return to their home communities to offer previously unavailable local access to justice. They were a legal interpolation of Wald’s vision of community nursing serving the poor and, like my own alma mater, Cornell, CUNY was based on a progressive educational vision. Its founders wove principles of humanistic psychology into its core structure for teaching “Law in the Service of Human Needs” (as their maxim states).

At first, I was greatly conflicted about the possibility of teaching outside my commitment to community health and my own private practice clients. Then, Rachel offered the first yoga class on September 10, 2001, the day before September 11. All my doubts fell away on 9/11, as my inner compass helped to reorient me once again and I recognized that we were being called to this law school, no matter how foreign or unlikely it appeared at the time. Almost as confirmation, on September 13, when the law school reopened, I was invited by Dean Kris Glen to address the entire law school community and share how meditation could help us heal during this time of uncertainty, as well as assist law students with their studies. My planned one-hour visit for a meditation class turned into five hours as I was introduced to faculty, staff, and students throughout the school.

There was no roadmap for this contemplative law venture; it had not been done before. These students were living a deep calling, intention, and commitment, as they were coming from and going to what Thich Nhat Hanh called the “blue flame,” the hottest part of society’s candle, living and working in some of the most disenfranchised, marginalized, forgotten, violent, and abandoned communities found in our culture and the world. I could see myself as a young nursing student in them, as they too were deeply committed to relieving suffering of those in need, especially the poor.

I began to investigate more about the history of the law school and through my inquiries, discovered that every dean since the law school’s inception meditated. To support my initial efforts, I began breathing with “not knowing” and called on those who came before us, including the previous deans, Dr. Martin Luther King Jr., the humanistic
psychologists who inspired the progressive curriculum, Thich Nhat Hanh, Merton, Nightingale, Wald, and the Native American ancestors who had originally lived on this small plot of land in Flushing, Queens, inviting from them all of their guidance and support. I found myself hugging exhausted and beleaguered students as I made my way down law school hallways and, like my teachers Thich Nhat Hanh and Dora Kunz, I wanted to offer them an engaged mindfulness practice based in compassion and self-care that was applicable to the challenges they were facing. I shared how to apply the energy of mindfulness to their everyday life and work and included what I had learned myself about resilience, self-compassion, and self-care from my studies and practice as a holistic nurse in underserved communities.

As in the past, I found myself once again in a situation with few resources and little support, but shared that we could be fueled by inner resources—loving-kindness, forgiveness, compassion practices, and a growing energy of mindful awareness within our community. Based on more than two decades’ experience of transforming health care through the inclusion of new healing paradigms, I explored, discovered, and included new worldviews of legal practice, offering healing alternatives for contemplative law students to forge their own pioneering path in social justice and public interest law. I invited pioneering attorneys who wielded innovative law initiatives to our contemplative, communitarian, and nonadversarial gatherings—the ushering in of a new healing legal paradigm. Sustaining social justice through love, when traditionally it had been fueled only by anger and outrage, is a real koan (unanswerable paradoxical story or question that can open us to a greater insight/awakening, beyond reason) for our society. By including therapeutic presence exercises (Anselmo, Bryant, & Goode, 2006) and heart-centered compassion practices to offset the heavy intellectual demands of law, my intention was that these students be guided not only by their heads but also by their hearts, their connection to purpose, and their spiritual awareness to become inspirational leaders themselves, ready to continuously transform themselves, their law practice, and society. These contemplative law students were being fostered by both law and nursing as they entered social justice. As such, they were spiritual offspring of both healing and justice, hopefully holding the best of what both our professions had to offer.

I found that my experimentation with personal and professional contemplative practice within the law offered a universal understanding that transcended any professional differences and emphasized our connectedness and the shared human experience of encountering suffering in ourselves and in the world, and underscored the vital importance of self-care in the face of human challenges. In 2015, our community, including faculty members Victor Goode, Maria Arias, Liz Newman, and myself, celebrated our 15th anniversary. Now hundreds of our students and graduates, along with once-skeptical colleagues, are practicing, writing, and teaching contemplative practice in law and social justice (Anselmo & Goode, 2016; Anselmo, Bryant & Goode, 2006).

■ MORAL/ETHICAL FOUNDATION

After the tragic death of a peace activist friend in the late 1980s, I found myself in deep shock, beyond the reach of any of the spiritual traditions I had studied or practiced. Unexpectedly, I learned of Vietnamese Buddhist monk and Zen master, Thich Nhat Hanh,
who was coming to the United States to offer healing to the American soldiers who had killed his own people. This was truly remarkable to me, as I was trying to heal from the tragic death of one friend, while Thay had lost hundreds of friends and family and thousands in his country and yet was coming to support those who called him an enemy.

In 1966, he founded the Order of Interbeing, a lay and monastic order practicing nonviolent precepts to guide their mindful, peaceful, and engaged actions and helping those in the midst of the war. For his work and stand for peace for all people, Thich Nhat Hanh was both exiled from his own country as well as nominated for the Nobel Peace Prize by Dr. Martin Luther King Jr. (King, 1967) and was called "my brother" by Thomas Merton (Merton, 1966, p. 18). Connecting with Thich Nhat Hanh—who, like Dr. King, Florence Nightingale, and Lillian Wald before him, has given his whole life to his deepest purpose, intention, and aspiration—and practicing in his Plum Village community of committed, engaged mindfulness practitioners, applying engaged mindfulness practice to my own life reflects my own true commitment to live authentically with integrity and intention. This living practice has enriched, opened, and deepened my spiritual path as a holistic nurse and as a human being. Many people ask me why I am vegan, do not drink alcohol, and make the life choices I make. Studying and practicing holistic nursing and healing since 1975, as shared previously, I found a natural coherence unfolding within me, moving me to change life habits incrementally, over time, without effort. The healing I was practicing was also healing me, working synergistically as a mutual simultaneous interaction, guiding me to live more in accord with my experience of nature's wisdom and my deepest aspiration to be compassionate to all beings and the Earth. So, eating less meat until I became a vegan and eliminating caffeine and alcohol were all just natural progressions over the first two decades of my holistic nursing practice.

Then, in 1991, I met Thay and heard his mindfulness trainings, both the 5 (Sitzman & Watson, 2014) and the 14 (Order of Interbeing, 2012). As I studied and practiced these trainings in my life and work, they elevated my own natural precepts to a new level. The 14 mindfulness trainings were written as Interbeing insights and global ethics in response to deeply held, underlying, unhealed personal and collective misunderstandings and disharmonies that lead to war, and, therefore, are a universal teaching for our times. Through living these trainings, Thay's early students developed a resilient and healing path through some of Vietnam's most difficult moments. Each training is an invitation to live more consciously, to be peace, and develop awareness of the ways we contribute to violence and suffering in ourselves, others, and the world. Reflecting a universal humanism, beyond the confines of religions, they focus on growing our understanding, compassion, and openness, beyond ideas of right or wrong, to become insightful practice partners. They do not require that we agree with each training to practice with them, as they remind us of the deep interconnectedness that is alive in every dimension of life and help us become conscious of the impact and implications of our choices, actions, words, and understandings or misunderstandings.

Along with these trainings, I have found the work of Laura van Dernoot Lipsky's (2009) Trauma Stewardship and David Berceli's (2008) Trauma Releasing Exercises (TRE) to be invaluable. These two resources have been a wonderful accompaniment to my mindfulness practice, helping me grow my capacity to be with what is, while becoming more attuned to my body's natural capacity to shake off tension and steward trauma, supporting my best efforts to embody inclusiveness, consciousness, healing, and
compassion, especially during times of real personal and community challenge. I found these to be especially helpful resources for rebalancing after a car accident in 2010 and helping my local meditation community recover from the impact of Hurricane Sandy in 2012. At Blue Cliff monastery retreats, I integrated TRE, Trauma Stewardship, and Neff’s (2011) Self-Compassion practice, with mindfulness and loving-kindness practice (Anselmo, 2016) during a retreat for healing professionals and one for Iraq and Afghanistan veterans, their families, and caregivers, with very positive responses.

From my own personal and community mindfulness practice experience, what has become even more clear is that integrating mindfulness practice with personal and collective values/precepts/guideposts within a committed contemplative community offers real potential for personal and community well-being and resilience, especially during the inevitable times of natural disaster or societal crisis (Anselmo, 2016). I have realized that throughout my life and career, there have been ever-widening circles of Interbeing awareness (all things change/are impermanent); we are not separate selves but inter-are with all beings in the cosmos; all is a continuation of all who have gone before and all yet to come and we are life without boundaries, like energy, neither created nor destroyed; and self-compassion (compassion for self, all beings, the Earth) naturally unfolds within me and guides me to deepen my commitment to Zen and holistic nursing practice.

I was ordained as a lay monastic in the Order of Interbeing by Thich Nhat Hanh in 1995 and received lamp transmission from him as a teacher/dharma holder in 2011 on the 45th anniversary of the founding of the Order. Traveling to Hanoi with Thay and the Plum Village international delegation during his last visit to Vietnam for the 2008 UNESCO Vesak Celebration and Conference, I held a Nightingale moment at a former Communist compound. Later that same week, I presented on “Mindfulness and Social Justice,” weaving together the inspirational threads and teachers of my life: Nightingale, Wald, Thich Nhat Hanh, and Dr. King. During the presentation, I evoked Dr. King’s definition of justice: “Justice is love correcting everything that stands against love.”

VISION

Over the last decade, Barbara Joyce, Jane Seley, Linda Saal (another Cornell graduate), Rosemary Sullivan, and I have worked within the former Cornell-New York Hospital (now New York-Presbyterian, NYP) to reintegrate the holistic wellness teachings and quantum nursing theory originally taught at Cornell and NYU 40 years ago. During these last few years, Jane Seley and the Cross Campus Nursing Practice Council have developed, received approval for, and integrated the NYP hospital policy on integrative health care modalities (IHM). Staff nurses who have gone through the NYP holistic nursing education program are now able to offer bedside holistic nursing practices and easily chart IHM. In the 1970s, Dee Krieger predicted that this integration would take 20 years, and it has proved, at least in New York, to be more challenging than she imagined, taking twice as long. At NYP, we offer not only holistic/integrative practice and the reintroduction of the Rogerian theory, but also the work of nurse theorists Jean Watson (see Chapter 16), Margaret Newman, Rosemary Parse, Elizabeth Barrett, and Barbara Dossey, as well as Nightingale and Wald. In this work, my intention has been,
once again, to seed new inspiration and practice for this new generation at NYP, so they themselves can further this unfolding continuation begun more than 100 years ago.

If I were to invite any consideration for what vital work we, as nurse leaders, have yet to complete, I would invite that we mindfully embody true public health for our global family to support well-being and justice for all, including the Earth herself. This would require a reorientation of our hearts beginning with a mindfulness-based personal and collective examination of ourselves and our society. If done with compassion and insight, such a reflection may open us to a new consciousness to understand the impact that we and our society have on each other, our global family, and our planet. Many, including Thay, see this awareness of our shared humanity, our Interbeing with all species and the Earth, as the next human evolution, becoming “homo conscious” (Nhat Hanh, 2010).

This radical departure from our current societal experience of well-being is not dependent on any personal or societal wealth, possessions, or consumption, but on the well-being of all as a capacity of our interconnectedness. How to begin? Start where we are. Walking mindfully down a hall, administering medication mindfully (Anselmo, 2016), or eating mindfully, we begin to embody this new possibility for ourselves, our families, our colleagues, our society, and our world. These practices may seem very ordinary, but offer a powerful way to embed mindful nurse leadership in everyday living.

If we choose to cultivate present moment awareness throughout our life, from my experience to date, embodying this Interbeing consciousness will naturally open us to ever-widening circles of awareness and compassion. Doing so, animated by this wise energy, we are gently guided toward living peacefully, healingly, and resiliently, even in times of great uncertainty. Nurturing this capacity, we ground ourselves in the present moment, so not to get as caught in fears of “what ifs?” It is natural that we may at times lose heart or inspiration, or become fearful or discouraged. In such times, two things are essential: first, stopping not only our activity but also our thinking, and taking a breath to embrace and calm our fears and be in deeper awareness; and second, practicing within a committed community, where we can lovingly remind ourselves and each other that as we cultivate cosmic homo consciousness, this collective evolutionary human consciousness is cultivating us, offering renewal and recognition that this endeavor is not ours alone.

Nurse healers know not to be attached to outcome and instead to trust the healing process. Applying the trust inherent in the healing process to our global environmental/social justice crisis is a very difficult and challenging practice in itself, yet, if we take this on and walk together in this great not-knowing, once again nurses, as society’s trusted profession of healing and compassion, will offer a path through whatever unfolds. As I look back at the vision of nursing I had as a new student nurse during orientation, I see it again with new eyes and recognize that it continues to invite me/us to grow beyond conventional borders of practice for nursing to be a great vehicle in supporting human beings to embody being truly alive, fully human, and humane. Nursing’s gifts need to be deeply embedded and embodied within humanity in all forms, beyond what is known as “nursing” in this present moment.

Ending this chapter, may we each, in our own way, awaken to our personal and collective heart’s healing and embody our true Interbeing humanity for ourselves, all beings, and our Earth.
REFLECTIONS

1. Reflecting on my journey, what has led me to nursing as my life path? What influences, connections, and ancestors have inspired my path?
2. What early experiences formed me as a nurse? How have they informed my practice as a leader and as a human being?
3. How is nursing a spiritual path for me in my life? What do I see as the message my life as a nurse offers? In what ways have I experienced this message embedded in myself and my work?
4. How have my values, understanding, and vision as a nurse expanded my sphere of professional practice? What role do I see contemplative practice/centering/mindfulness playing in my life and nursing practice?
5. What roles do nurses, spiritual practice, and spiritual community play in cultivating collective resilience, healing, compassion, and justice? In what ways, besides writing, do I transmit or embody these dimensions of nurse practice and leadership?

REFERENCES


CHAPTER TWO

Translational and Indispensable: Using the Gift of Foresight to Reenvision Nursing

Michael R. Bleich

As a discipline nursing has been cautious, steady, and ever caring, traits that are desirable but insufficient in a time of unprecedented chaos and complexity. . . . The pool of talent . . . is formidable. In fact, we see “translational workers” emerging—people who see a bigger picture, think through the options for and impact of care delivery changes, embrace solutions that include policy development, utilize research for promulgating evidence-based clinical practices, and value research with an eye toward organizational systems and administrative best practices. . . . The value worker of the future may likely be the person who moves fluidly between academic and service settings, demonstrating expertise in both.

—Hewlett and Bleich (2004, pp. 273–274)

WHY NURSING?

My early career experiences shaped my sense of the variety of roles nurses could play, the possible accomplishments of nurses over a career, and the human resource potential of nurses. From designing hospital-based care systems in two acute care hospitals to creating forums for advancing nursing roles through educational achievements and making complex ideas applicable to nurses and the health team, it was obvious to me that nurses would attend to a range of human responses.

The human response to health and illness meant nurses would promote health, intervene in the presence of disease, and champion disease abatement efforts while coordinating care to enrich human functioning. I call this the gift of foresight: sensing the future of nursing and leading efforts toward a preferred future for the discipline. Through it, the opportunity to serve on the Institute of Medicine (IOM) committee that would write
the report *The Future of Nursing: Leading Change, Advancing Health* would emerge. Interacting with the public, nurses, health providers, and health system leaders in governance roles; the opportunity to champion the discipline, both in the United States and abroad; and the chance to address diversity and inclusion of the workforce through systems design and structural barrier removal continues to resonate through my work. Given experiences in both service and academics, I envisioned myself as a translational worker, someone to bridge both aspects of the discipline.

Without question, I did not grow up wanting to become a nurse. Being a music teacher was my destiny. But piano lessons led me to a job in a county-operated psychiatric facility, as the administrator’s daughter took piano lessons before my half-hour turn at the keyboard. Always early, the hospital administrator talked with me and put it out there that on my 18th birthday state law would permit me to work in a mental health facility. So it came to be. Living in rural Wisconsin and needing to pay my own college expenses, my birthday marked my entree into health care. While donning a white *Ben Casey*–style side-button top, white pants, and shoes, I was called to duty.

Many stories can be tied to this first position as an orderly. A licensed practical nurse (LPN) taught me to administer medicines and perform treatments for which I had no clinical knowledge (her duty hours ended when feeding patients dinner concluded, leaving me alone on a 36-bed ward until the third shift arrived). No telephone communication existed between the buildings. Rather, communication between buildings was possible through the use of an archaic intercom system. By pulling a lever, clicking sounds to another building might work and could be heard if the lone RN on the other side was close to the nurses’ station. Patients were expected to help provide care to other residents, a situation not uncommon in custodial settings. The 4–2 work schedule allowed you to plan your work schedule for years in advance. Four days on, two days off, with one full weekend off, each seven weeks apart. With a stable patient census, this plan was highly efficient, yet offered no work–life balance. It was never questioned in the several years I worked under those circumstances.

In spite of the obvious challenges, the work held allure for me. Another classmate from the high school I attended was hired and started a day later than I did, coinciding with his 18th birthday. During my first year attending a teacher’s college, Steve convinced me to leave the college I was at and commute with him to attend the LPN program in Madison, Wisconsin. Steve and I commuted for the year and leaned on each other, quickly coming to grips with being outliers in a female-dominated profession. Although many professors were kind and encouraging, there were those who made being male tense and difficult. Youth served us well, not knowing whether we were experiencing inequitable education or clinical opportunities from these few faculty.

At the onset of my career and education, nursing was about helping others, performing tasks, and communicating observations, especially through charting. In my mind, it really was not more complicated than that. And I learned that fewer questions about masculinity would be asked if I quickly stated that my interest was in mental health, or later, orthopedics, where having men help with lifting justified being present on the unit.

### EARLY IMPRESSIONS

My first role as an LPN was in a state facility, caring for men who were profoundly developmentally disabled. As I reflect, this was another setting where being a male was
not questioned. Professional staffing was sparse and unionized nursing assistants (NAs) provided care based on their NA career ladder ranging from NA1 to NA5, with the top (NA4 and NA5) being supervisory over a cottage, where residents lived, or a cluster of cottages. NAs did not report to either an LPN or an RN, so one learned quickly that relationships and collaboration meant everything if a nurse was to survive or thrive through a shift. Fortunately, the NA4 who was my link to the core NA workforce was older, wiser, and collaborative. She provided me with important insights on the various medical conditions that impacted the residents, the most prevalent being seizure disorders, where at any given time, three to five residents could be experiencing a seizure. I recall that individuals who were developmentally disabled were afflicted with many rare clinical disorders well beyond what would be covered in traditional nursing education.

With this first nursing position came a stark realization that many parents had abandoned their children, essentially making them wards of the state. This instilled in me a sense of being responsible for the quality of life and functional existence of these residents, who ranged in age from early childhood through senescence. Safety and security were a paramount nursing focus, but so was bringing small bits of joy into the workplace. Caring for a minimum of 90 residents demanded a high level of organization and time management in medication administration, treatment provision, charting, and emergency management. Communicable disease outbreaks were not uncommon. Shigellosis, a bacterial infection impacting the digestive system, meant that the cottage was placed on isolation and extreme procedures were implemented, including administering antibiotic regimens for all residents.

In this first year as a nurse came the jolting knowledge of patient advocacy. One full-time physician covered 1,200 residents, performing perfunctory history and physical examinations, addressing medical emergencies, and prescribing medications that today would stun the public. An African American teen on my assigned cottage was unusual in that his intellect and verbal communication skills were of a much higher level than the other residents who were nonverbal. This made him eligible to participate in a sheltered workshop day program. The female physician had expressed to the NA4 her fear of his size and race and so placed him on a drug to diminish his sex drive, the side effect of which was breast development.

The young man came to me and expressed—in today’s terms—that he was bullied by others on the bus ride to and while at the workshop because of his breasts. Following a communication protocol, I queried the physician by leaving a note as to whether an alternative drug could be used and mentioned that the resident was able to discern the side effect of breast enlargement.

Two days later, while pulling into the parking lot, the evening supervisor, an RN, informed me I was in trouble. Stunningly, it was because of the note. The physician demanded a reprimand for questioning her order. On entering the building, I was quizzed, “What were you thinking? Do you not respect physicians’ orders? Do you realize the physical harm this resident could do?” My answers were direct:

The resident realized he was shaped differently than other boys. His behavior on the cottage, before the drug was prescribed, was always docile and he was easygoing. I was asking if there was an alternative to the prescribed drug, not suggesting one nor saying that the order was not justified.
Lesson learned: Patient advocacy involves risk-taking and remembering that not all health providers are patient advocates. Back then, physicians wielded power beyond my youthful and naïve imagination. Most disappointing, I learned that the director of nursing was said to have stated, “He will never amount to anything if he does not adhere to physicians’ orders.”

Standing up for this resident was frightening and anxiety provoking in that I could have lost my job. The tact of the evening supervisor who believed that I did the right thing led to calming the situation, but there was no change in the resident’s prescription. The RN supervisor became my first role model. The role of the nurse as an advocate remains central to my practice today and was a driver to return to school.

In the nursing shortage of the 1970s, many employers were eager to hire nurses. I started my second job as an LPN at the conclusion of an interview with the human resource director, who rode with me on the elevator and, upon arrival at the third floor, introduced me to the evening charge nurse. That was the extent of orientation and I worked a partial shift that very evening. Orthopedics was considered an ideal setting for men, as the heavy hip spica casts and need for lifting assistance were plentiful. Nurse after nurse and patient after patient would tell me how good I was good at lifting and how I was needed on that unit. No mention was made of any other abilities I may have possessed. In this acute care setting, LPNs were active caregivers in a team-based care model, meaning that we performed specific nursing tasks for a group of patients and, if assigned as a team leader, provided supervision to NAs.

Survival on orthopedics required team efforts so the staff worked in tandem. In this team care model, the RN was poised at the nursing station to take phone calls and round with physicians, make assignments, perform the task of checking off orders with the ward secretary, and answer questions from visitors or family. RN engagement in care delivery was limited to critical situations; offering nonemergency assistance to the team was not a charge nurse responsibility. Again, I observed hierarchy and role delineation that made me question wanting to become an RN, although I was in a diploma school at the time.

Over the years, some have asked why I chose a diploma program. The choice of this type of nursing program was made for three reasons: The diploma program I attended had a history of admitting and graduating men (one regional college had a policy where you could be admitted, but they would not offer a degree to a male), and there were still other nursing programs that would not admit male students. Practicing nurses said that diploma programs reflected excellence and real-world knowledge. Finally, once accepted into the program, a clinical placement was assured. This was unlike state school baccalaureate students who, after two years of study, went into a lottery to determine if they would have a clinical placement (if not, these students would be required to change majors, a risk many were unwilling to take).

These early positions provided me with few role models, an uncertain perspective on the discipline as anything more than serving physicians, and feeling used by females in positions of hierarchy. At the same time, I enjoyed my peers and the work of patient care. To remove myself from the role of full-time lifting, the only other viable option available was to become a float nurse. It proved to be a wise decision.

The success that went along with becoming a float nurse was as much psychological as anything. Every unit to which I was assigned was happy to accept the resource. Floating demanded less engagement in unit politics, and I could differentiate how various units
performed. Although rare, access to other men who were successful as nurses made me feel less an outlier as I witnessed their integral function in the emergency department, surgical intensive care, and surgery. Mostly, my skills were sharpened by learning new procedures and techniques. But the primary lessons as a float nurse were found in the close working relationships with the evening supervisors, three very strong and patient-centered nurses (Dianne Younk, Sr. Gabriel, and Margaret Krummel). They helped me link and understand patient needs as universal, across clinical unit boundaries. For instance, treating surgical pain may be different from orthopedic pain, but it is still pain that has to be managed, and I had a role in that. These broad perspectives led me to appreciate patient-centered care.

PROFESSIONAL EVOLUTION/CONTRIBUTION

After becoming an RN, emergency nursing was next in line. Working in an inner-city hospital, many victims of violence and trauma presented. Intense teamwork, strong clinical reliance on professional peers, and high volumes of patients made the work seem important—and we did save lives. It was also a time where issues in the public’s health ended up at our doorstep. Air pollution led to asthma attacks. Obesity and smoking led to heart attacks. Heavy equipment and chemical-based industries led to workplace injuries, often musculoskeletal in nature. Sexual freedom led to sexually transmitted diseases, which were treated and referred. From this role, and without having a formal name for it, I grasped how social determinants impacted emergency and acute care services, a perception that was strongly reinforced several years later while pursuing a graduate degree in public health nursing and patient care administration.

After cutting my teeth in emergency nursing, I was called to the nursing office to meet with the director of nursing—a very different experience than with the first nursing director. She knew of my work and my work ethic and offered me a role in staff development to assist in the development of a new medical center. The clinical pace and challenges of emergency nursing were appealing but the opportunity to teach resonated. In staff development, my earliest desires to be an educator could be fulfilled. In terms of working with the development of the new medical center, it sounded exciting yet I had no context for what it would mean and how it would change my career trajectory.

At this juncture in my career, serendipity led me to an interest in hospital design and how it was linked to nursing practice and patient outcomes. In the late 1960s and early 1970s, Canadian architect and hospital administrator, Gordon Friesen, made waves in the design of hospitals, not unlike Nightingale’s impact in hospital reform (Bellwether League, Inc., n.d.; http://www.bellwetherleague.org/bellwethers-2009/hall-of-fame/2009-honoree-Friesen-Gordon.html). The new medical center I was to be part of creating was modeled after the Friesen concept. Learning about this concept and representing nursing on architectural planning groups was extremely stimulating. Two site visits to hospitals built using Friesen’s innovations opened my mind to how care could be delivered in a decentralized model, where each patient room was designed to be the nursing station.

Friesen had a great affinity for nurses and nursing from a health systems perspective. He believed in the use of technology to enable care, so pagers were employed to facilitate communication, a major breakthrough for its time. Nurses’ stations were eliminated and work redesigned so that charting, medications, and treatment supplies were
housed at the point of care in Nurservers, air pressure–balanced cabinets to keep clean supplies clean, and soiled linens and equipment portioned off to reduce contamination. Replacing semiprivate and wardrooms, all rooms were private, allowing for improved patient–nurse communication and accommodating the presence of family. These were but some of the concepts that made Friesen hospitals unique from the traditional ward structures that emanated from Victorian principles of work design and orderliness. All of the activities linked with the construction of this hospital catapulted my beliefs about nurses as value-added care providers, granting me granular insights into the centrality of the discipline from an interdisciplinary perspective. Whether materials distribution, food service, life safety systems, or communications equipment, all had to be designed to intersect with point-of-care service from the first patient on.

Many of the Friesen concepts have been reintroduced in recent years with the Transforming Care at the Bedside (TCAB) initiative, speaking to the foresight and clear end-point vision that Friesen had for work design and optimal patient experience (Rutherford, Lee, & Greiner, 2004).

Throughout these experiences, as I reflect, there were individuals who strongly believed in me and offered encouragement. Two names come to mind, of many: Sr. Catherine Albers and Catherine Kirk offered encouragement and prayer, which impacted my self-confidence and motivation to be and do the best I could.

When coupled with the emerging practice of primary nursing, also prevalent in the late 1970s and 1980s, I found myself on a team creating a care delivery model that fully aligned with my personal thoughts and beliefs about what nursing could be.

The experiences throughout my 20s and 30s profoundly impact me today. The following are some of the leadership lessons learned during this time frame:

- Social determinants and public and environmental health issues shape the nature and type of acute care services that are delivered.
- Nursing is relationship centered and the work environment can be designed through structures and processes that increase the opportunity for positive clinical outcomes directly influenced by nurses.
- Systems thinking is an essential leadership skill. Systems are embedded in other systems. A hospital is a set of commingling disciplines sharing space, which if not designed with intent, often results in chaos, parallel play, or medical error. If job role and the care delivery system are designed with intention, then seamless and collaborative patient and family care emerges that feels organic to health care workers. Alternatively, processes that develop unilaterally without systems awareness often exist with historical roots. Symptoms of poor work design can be found in the statement, “That is the way things are done here,” an overdependence on coordinators to navigate poor systems, and patient care being a neglected by-product, where nurses nurse the processes rather than the patient.
- Too few leaders are willing to take on complex systems design because it disrupts job roles and power structures and involves risk, conflict, and negotiation skills.
- Teaching is a leadership and management skill. Teaching can be synonymous with communication but it implies more. When leaders teach, they are in relationship with their stakeholders in a manner that models caring through a developmental commitment.
In more recent decades, the influence of strong leaders has led me to value being mentored and being a mentor, especially in organizational science and scholarly development. With an acute care nursing background, teaching in a degree completion program for RNs and developing a consulting practice linked to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) gave me substantive exposure to health care organizations within the United States and abroad. Each of these experiences, in addition to doctoral studies in human resource and organizational development, strengthened the way I embodied how an organization’s mission, vision, and values drive the nature of the work to be accomplished; all of which are insufficient without aligning structures and processes to support human resource optimization. Comfort in acute care and other clinical settings complemented my interest in educational roles.

After being so close to patient care providers and organizational leaders, and engaging with them to solve complex organizational problems, the need to publish and develop a scholarly portfolio was a practical solution to give something back to the field, where too little was in the literature. To this end, Dr. Sue Ellen Pinkerton and her team at St. Michael Hospital in Milwaukee, Wisconsin, were impactful in modeling that doctoral education provided unique ways of thinking, new tools to use in decision making, and expanded contributions to the profession. Nursing process, nursing documentation, quality improvement, standards development, access to care, and other organizational topics led to an editorial appointment on the board of the *Journal of Nursing Care Quality*.

Mentors Drs. Karen Miller, Jan Bellack, Shirley Chater, Maryann Fralic, and Jona Raasch, all leaders with substantive organizational, policy, governance, and leadership competence, nudged me to look at expanded leadership opportunities. The University of Kansas School of Nursing was my entrée into academic medicine, academe, and expanded interprofessional teaching in organizational leadership and health policy and management. The School of Nursing and the School of Allied Health had separate practice incorporation as part of their respective missions. Serving as an associate dean with responsibilities for the practice mission, exposure to governance structures, and bridging faculty practice with student learning to serve the public helped students learn the organizational side of patient care. Note the confluence, once again, of practice, teaching, role development, and policy aimed at systemic change.

One of many highlights of this experience was the privilege of leading a community-based clinic, exposing students to diverse, underrepresented, and un- or underinsured residents. Faculty and students in organizational leadership, advanced practice nursing and advanced therapies, health care informatics, and basic nursing and medical students cut their teeth on designing patient-centered processes for each program that expanded the growth of the clinic.

Part of an academic’s career is pursuing an area of scholarship. The portfolio of publications I had contributed to the field at that time consisted of field-based necessities, but was insufficient to claim as part of an academic profile. As an academic, two areas surfaced that fueled my interests and built on my past: systems leadership and workforce development, including supply and demand.

Clinicians, especially at the advanced level, are dependent upon the structure of organizations and how work is designed. Quality science had advanced to the point where each improvement project required its own processes. When implementation plans failed, it was often because the improvement strategy stood as a separate set of practices
from existing processes. Stand-alone protocols, those disconnected from organizational processes, accelerated *work-arounds*, a term synonymous with a set of actions outside acceptable routines. Work-arounds provided evidence of a protocol's lack of fit within existing processes. Teaching about and modeling the design of systems was an important contribution to quality and implementation science, preparing a workforce to enable systems leadership. Work-arounds add complexity to routine practices, which could include bypassing safeguards that ensure the quality and safety linked to patient care.

Concomitantly, the National Research Corporation that sponsored the Picker Institute afforded me the opportunity to serve as an expert panel member to focus on access to care. The work of Harvey Picker, an important manufacturer of radiologic equipment for use in health care, was advanced largely due to the illness of his wife. Dr. Picker was the first to promote patient-centered care from the perspective of organizational systems and processes. Picker bridged technology with patient experience and developed instruments to measure the effectiveness of the patient's perspective in the design of care processes. In addition to the focus on access to care, Picker's research (Gerteis, Edgman-Levita, Daley, & Delbanco, 1993) named several patient care principles, such as respect for the patient's values and expressed needs, care coordination and integration, high-quality communication used to educate the patient and family, physical comfort, emotional support, family and friend engagement, and seamless care transitions, all of which align with today's commitment to care through the Affordable Care Act.

Analyzing the needs of the workforce from a perspective of supply and demand also seemed important, having worked for years on the demand side (service) before moving to the supply side (academia). Nursing curricula development is not a nimble process. Creating enrollment targets and hiring faculty to fulfill the needs of those targets is a longitudinal initiative. The national Colleagues in Caring: Regional Collaboratives for Nursing Work Force Development program, my first interaction with the Robert Wood Johnson Foundation (RWJF), which funded national workgroups on workforce supply and demand, seriously examined workforce issues. Here, with colleagues in the greater Kansas City bistate region, we developed a role- and function-based data collection instrument. Rather than capturing subjective data about the anticipated numbers of nurses needed, the instrument measured projected knowledge and skill sets needed to ensure that nurses would be prepared with requisite competencies to align with the employment opportunities, which today I refer to as “staging the workforce.”

What this essentially means is that academic institutions must align their graduates for the job opportunities available. Too many nurses available without work can become demoralized and/or deskilled. Too few nurses available, for a prolonged period of time, creates critical gaps in patient care. The workforce model that I explored with Dr. Peggy Hewlett called for bridging supply with demand, competency attainment based on a continuum of workforce settings where nurses were employed, and staging a workforce to ensure a relatively steady state of employable nurses. These data fostered a stronger bridge between academic and service partners.

RWJF was instrumental in my leadership development, and I became the first man to be accepted into their Executive Nurse Fellows program. Later they would fund the Wisdom at Work project, which examined the issues of the impending loss of senior nurses with years of experience. This contribution led many to examine the impact of lost knowledge and develop workforce plans to shore up programs to recognize the
importance of mid-career hires and to use technology to capture the wisdom of experienced nurses. The work of David Delong (2004), a national expert in the impact of workforce turnover, knowledge capture, and talent management, profoundly informed the Wisdom at Work project.

This leadership development afforded me experience in academic–service partnerships that spanned a career, and the interest in workforce pipeline led to the privilege of leading two nursing schools at Oregon Health and Science University and at the Goldfarb School of Nursing at Barnes-Jewish College. Both schools are embedded in a service milieu with ties to major academic health sciences programs. Both have achieved renown for innovations in education and research, with strong alliances to practice, including Magnet hospitals. Both were environments where opportunity presented itself to implement the findings of the IOM’s (2011) report entitled The Future of Nursing: Leading Change, Advancing Health.

In what was a career-changing opportunity, I received the call to interview to serve on the committee for the RWJF Initiative at the IOM. It was both humbling and daunting. The interview clarified the diversity of the committee and that five nurses would serve on the group. By regulatory design, the committee would be interprofessional and the study would meet the rigorous criteria established for all IOM reports. The chair would be Dr. Donna Shalala, past secretary of the U.S. Department of Health and Human Services and known to me from my days in Wisconsin, where she was chancellor at the University of Wisconsin–Madison. My role would be to represent nursing education from a futures perspective. And for the first time, the IOM would partner with the RWJF with the aim that the foundation would support implementation funding.

Serving on such a committee is an experience that I wish could be shared with others. From the onset, where the charter is reviewed, to when committee members formally introduce their biases such that all are aware of the perspectives represented, to the rigor of accepting only the highest quality of research from which to write the narrative and recommendations, yields a process that affords great confidence in how science serves our nation.

Dr. Shalala masterfully framed that the report was to reflect the public’s current and future expectations of the nursing discipline, not a report about nursing for the benefit of nurses. With agility, she engaged each committee member and the formidable and far-reaching expertise each possessed. With policy awareness, she maintained astounding insights into how the Affordable Care Act was progressing to ensure that our report was contextually relevant. Dr. Shalala also modeled something that we, as nurses, may often be too timid to confront: to immediately seek out the brightest and best talents when confronting complex and difficult situations. Go to the top players in any given field to expedite knowledge generation that may already exist—a lesson that I have grown into.

Along with Dr. Linda Burns-Bolton as cochair, and Dr. Susan Hassmiller, the senior adviser for nursing at the RWJF, resources were plentiful as the depth and breadth of nursing’s contribution to health care unfolded. National hearings on acute care and technology, community-based care and public health, and nursing education were conducted. Each hearing was rich with evidence from experts, public testimony, and opportunities to clarify and expand on issues. Commissioned papers were summoned. Research was conducted when needed by health systems scientists.
Throughout the nearly two-year process, several aspects struck me as crucially important. The first is that when you are trained as a professional and gain a particular framing lens (in this case, nursing), it becomes increasingly difficult to see the discipline through the lens of those you serve (the patient) and other disciplines. The time to listen through the patient’s eyes revealed more than just their trust of the discipline. It showed how critical nurses are in every venue where nurses practice and through every stage of the life span. Since the IOM’s (2011) final report, *The Future of Nursing: Leading Change, Advancing Health*, was released, I have shared this message with thousands of nurses whom I have encountered and addressed.

Second, health care is complex, but not less complex than nursing’s own history and role within the health system. Consequently, messaging to all stakeholders is essential. Complexity must be expressed through messaging that is accessible. That the report had four key messages and eight concise recommendations was by design. The title of the report was carefully constructed. The tone and inclusivity of the writing was thoughtfully executed to be accessible to the public, policy makers, other health disciplines, and to nurses. Transforming complex messages into language that has functional utility is anything but simplistic; it is artful and requires great skill to achieve.

Third, emotion trumps the facts. Repeatedly, individuals and groups would attend hearings, wanting to be heard. They had stories, good and bad, sad and hope filled. When their emotions were released, only then could their minds handle the data that was being accumulated and synthesized. Skillful negotiations, being comfortable with conflict, and using evidence is a powerful combination when creating a blueprint for social change.

There are many ways that *The Future of Nursing* report has influenced and is changing the nature of the discipline. State action coalitions continue to create agendas around the report’s findings. Many professional nursing organizations have used the IOM report as a stimulus for their specialty work. Nursing journal editors have spread the messages and recommendations to multiple stakeholders. Policy makers have responded to the call to expand the role of advanced practice registered nurses (APRNs). Nurses have returned to school to complete their BSN degrees in record numbers, as health care institutions and states realize that nursing is a high-stakes profession. New research has been generated to support policy development aimed at fulfilling public expectations, documenting the public’s readiness for nursing to expand its scope of practice. Nursing curricula have been revised and reshaped to accommodate seamless education through to the doctoral level of preparation.

Knowing how this report has catapulted nursing into expanded arenas and has educated the public as to the nature of the discipline is beyond anything I could have imagined during the intense efforts it took to create this scholarly work. Beyond extensive efforts to bring the messages to countless audiences, there are several postreport developments that resonate with the contributions I am trying to make:

- I have accepted a volunteer role with the Governance Institute, a formidable organization that deals with board development for major health care institutions and systems across the United States. Initially, too few boards were aware of the report. Once they were, their attention turned to nursing education, particularly surrounding APRN roles. APRN roles (nurse practitioners, clini-
cal nurse specialists, midwives—who may or may not be nurses—and nurse anesthetists) are poorly grasped and confused with the physician assistant and primary care physician roles. The effort to educate and advise boards on these roles, and to press for the inclusion of nurses on boards and board committees, remains important to me.

• The global context of nursing is expanding my way of being. The fortunate relationship I have chairing the board of the Commission on Graduates of Foreign Nursing Schools (CGFNS) International has connected me to the issues of global nursing and other health discipline migration, no longer just in the United States but in a variety of global locations. How professional credentials are evaluated, authenticated, and verified, along with certification and assessment examinations, is a field of expertise that addresses new issues surrounding supply and demand and changes in educational requirements. The focus of this work is to protect the public through the preparation of practitioners who can deliver safe, quality care.

• Research has become increasingly important and my advocacy efforts have expanded. The role of the National Institutes of Health, especially the National Institute for Nursing Research, is important to expand clinical research through a nursing model. Few other health disciplines attend to symptom management, end of life, and other forms of science that bridge the human response to disease. But advocacy for organizational research, including care delivery evaluation and impact across an expanding health care continuum, and informing state and national policy agendas has never had more meaning to me. Having examined the relevance of the latter forms of research through the IOM (2011) study, we have too few scientists informing health systems and policy. If nursing is to influence the systems of care, including economics, then we must advance nursing research to these broader perspectives. These are the messages and initiatives I support through current involvement with the Friends of the National Institute for Nursing Research (FNINR). The message here is that a personal passion has a home, somewhere, with like-minded advocates.

• Last, but not least, I have taken time to deeply commit to the diversity and inclusion agenda to enrich the discipline. Serving on the national Bipartisan Policy Center’s Health Professional Workforce Initiative Expert Advisory Panel, it was stunning to realize the advancement of every health profession with regard to diversity with the exception of nursing (Keckley, Coughlin, Gupta, Korenda, & Stanley, 2011). While writing the report, too few studies on diversity and inclusion were available. What was known is that national demographics are shifting, and without men entering the profession and cultural and ethnic expansion into the discipline, workforce shortages will be extremely exacerbated. The reduction or elimination in service and academic structures of an existent and willing workforce to accept modified ways of teaching and being a nurse will seriously challenge those who remain in health care.
I started this chapter by saying that nursing had never entered my mind as a profession. Let me now add that I grew up with a stern father who believed in traditional discipline and hard work and a mother and maternal grandmother who were extraordinarily kind. My siblings and I were taught to “do unto others as you would have done unto you.” We were expected to demonstrate respect to those who were older, in how we addressed them, and even how to walk on the outside of the sidewalk so they would be protected from the street. It was very important to my parents that all people be treated with dignity. In reflection, these childhood values and expectations are ideal nursing traits.

There were but five or so Catholic families in the small village where I grew up, mine among them. Most of the residents of Rio, Wisconsin were staunch Lutherans, first and second generation from Norway. Church and public school was commingled, without separation of church and state, and the teaching faculty were primarily local. This is to say that I felt like an outsider even though my entire grade and high-school years were spent in Rio.

When I was 10, my maternal grandmother became very ill (she was in her late 50s at the time). In an era where there were still “hospital zones” where noise was to be limited, children were not allowed into hospitals. Realizing how grave my grandmother’s health was, we were taken to the hospital to see her for what would be the last time. We stood out on the sidewalk looking up at my grandmother’s hospital room and a white-capped and uniformed nurse eased my grandmother to the window. I can still see my grandmother’s faint smile and gentle wave of her hand as my two brothers and I waved back. This went on for several minutes. It is the last remembrance I have of my grandmother before she passed away.

This story is a reflection of the kindness of the nurse and the respect she had for my grandmother’s grandchildren. It represented an era in time where patient-centered care was not a strong value. Rituals, protocols, and a lack of evidence-based practice, instilled with European norms, reigned. Social justice, valuing relationships, and doing the right thing as a way of adapting to different realities were what morally made sense to me.

The most tragic—yet values-clarifying—experience of my career came about after accepting my second position as a chief nursing officer at a hospital in the heartland. On my first day at work, the last of a series of patients died from cardioplegic solution contamination. The moral–ethical dilemma related to the pressure placed on a pharmacist provider to follow a mandate enforced by authority figures, forcing the pharmacist to create a solution from a protocol that was later deemed as “manufacturing a drug,” which was not allowed in a hospital setting and subject to Food and Drug Administration regulations. The subsequent deaths of patients served as strong reminders that each health professional has a moral duty and obligation to serve in the best interests of the patient. Beyond the tragedy of patients’ lives lost, after regulatory reprimand, the pharmacist committed suicide. Although extreme, this scenario reminds us that there is moral–ethical distress in the high-stakes business of health care, where values and beliefs are tested routinely. Today leaders are, hopefully, more likely to recognize and respond to the moral and ethical stress and distress that a crisis can create but also the toll of caregiver compassion fatigue over time.
As the opportunity to be in service and academic leadership positions has filled my career, and opportunities to influence social policy as described earlier continue to present, I have tried to find the balance in providing structures that offer a sense of direction and orderliness, but have done so with an eye on the end point vision. The Picker work on patient-centered care and the Friesen work on design reflect the creation of spaces to provide structures that address doing the greatest good for the greatest number, yet find a balance in personalizing care. As a dean and college president, I try to find the balance in ascribing to academic and professional standards needed to model expert and vigilant nursing care to the public, while encouraging faculty innovation and adaptation to address the learning and personal needs of students; and ensuring policies, procedures, and practices as adjunctive support to aid faculty and staff who benefit from structure, while also honoring academic freedom to stimulate creativity. Academic environments are best served when students find respect, balance, creative outlets, and rich and diverse perspectives to stimulate holistic growth. In this kind of environment, moral and ethical development can evolve and flourish.

VISION

In a world that is complex in many ways (socioeconomically disparate, ethnically and culturally expansive, religiously ideological, violent, technologically sophisticated, environmentally challenged, and more), nursing has never been more needed. Nurses are, at the end of the day, when all knowledge of disease and the treatments that accompany the eradication of disease are exhausted, the instruments of healing. Comfort, hope, encouragement, and gentleness may be all that is left when each of us experiences the final pages of our life.

The scope of nursing practice should not be constrained in any manner. Holistic care that aligns with human responses to life challenges are fitting dimensions of nursing practice. That the science of our discipline can enrich the alleviation of pain, manage self-care deficits, or elevate the patient’s acceptance of self and family provides nondisease-based treatment options. Nurses can expand their practice to include diagnosing and treating disease as a natural part of a nursing portfolio, but view care through the lens of a nurse, not of a physician. For this reason, I envision a stronger presence of nursing in all parts of the community: churches and schools (where individuals and families gather and where health and well-being are introduced), hospitals and ambulatory care settings (where humanistic care is critical when disease is being diagnosed and treated), primary and specialty clinics (where a nurse is an adjunct and a team member to physicians), palliative and hospice care (where pain management and psychosocial and spiritual presence is offered), correctional facilities (where we have come to house too many with mental health disorders), and public health and transitional care and other settings.

The vision here is that we nurses will remain present in the social situations where people live and reside, in the spirit of Nightingale and Lillian Wald. We will remain educated to have exposure across the life span and to experience the onset and ending of life. We will be advocates for those whose voices cannot be heard, representing their strengths and dignity, not as a discipline that dwells on incapacitation.
Education will vitalize the discipline. A strong foundation remains important, where in addition to all aspects of disease and illness care, nurses will prevail in developing more than how to “do” nursing (tasks and procedures), but become role models of how to “be” a nurse (as a healer and advocate). Diverse and inclusive teams will bring enriched knowledge and sensitivity to care settings, and there will be space for all who have the traits to engage in nursing.

Our science will be used in new and expanded ways. Physicians will come to realize that nursing science is a necessary complement to medical science; all disease and treatment options create human responses, which must be understood to be acceptable. Bench science will enrich physiologic knowledge; translational science will provide the context and use for what is discovered at the bench level. Individualized care will be strengthened through personalized medicine. The ethical dimensions of personalized medicine will require examination and understanding from both a use and a risk perspective.

Nurses in advanced practice roles will complement physician-delivered care in a balanced manner. Turf wars (mostly driven by concern for loss of reimbursement) will diminish as newer generations of physicians and other health professionals realize that all citizens need health and illness care. The mindset of only providing care to those with fiscal access will be recalibrated as nurses speak to this imbalance. The public and legislators will come to realize that a healthy citizenry is linked to an educated and able workforce. It is in the best interest of businesses to work with nurses and other health team members to invest in wellness.

Finally, health systems will be designed to be seamless and continuous rather than needlessly complex and disjointed. Nurses will play a strong role in the design of these systems through education, training, and presence in settings where care is needed. Nurses will play a role in ensuring that patients and families are also at the table where care design takes place. Our role in care design at the institutional level will not be trumped at the policy level as we bridge institutional policies and practices with state and national policies and practices. Our contribution will be to bring coalitions together to afford needed change in the health system.

This may sound too idealistic to classify as a vision. Perhaps. But I know of nurses who are champions in each and every one of these areas today: nurses who are systems leaders and who have the public’s interests at heart to ensure that a workforce is present that is cognitively, technically, and morally/ethically able to communicate and function independently and in teams. Nurses with foresight need to act as translational workers, a necessary part of the hub of social change.

**REFLECTIONS**

1. *Who have I experienced in my career that meets the definition of a translational worker, someone who can transcend service and academics? How does this professional play an important role when interacting with others?*
2. *In thinking about the IOM report, The Future of Nursing: Leading Change, Advancing Health, what has this blueprint for the public’s health done to elevate nursing from my vantage point? Have the findings and recommendations from this report changed my practice or career trajectory?*
3. When someone says that he or she is a “systems thinker,” how does this differ from someone who says he or she thinks systematically?
4. How does the physical and process design of a health care facility influence clinical care delivery and patient outcomes? Think of an example that would enhance care and one where care was impeded.
5. What are the work-arounds I have observed in my clinical, educational, or research setting? How do the work-arounds affect safety and outcomes? Which protocols are not in congruence with the existing processes? How can I go about fixing it to improve quality, safety, and outcomes?

REFERENCES