

Leadership for Relationship-Based Care
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Good morning. It is my pleasure to introduce the distinguished nurse who developed the concept of Primary Nursing, Marie Manthey. Marie is founder and President Emeritus of Creative Health Care Management, a full-service consultation company specializing in professional practice, management training, staff empowerment, and work redesign. Marie's interest in the delivery of hospital services began in the 1960s, when she developed the concept of Primary Nursing. Since that time she has designed and implemented Primary Nursing programs for numerous hospitals. Prior to consulting, Marie held positions at every level of nursing, from staff nurse to vice president for patient services. Marie received her nursing diploma from Saint Elizabeth's Hospital in Chicago, and both her bachelor's and master's degrees from the University of Minnesota. In 1994 Marie was elected to the Royal College of Nursing in the United Kingdom, at the time one of only four American nurses to be so honored. In May 1998 she was selected for fellowship in the American Academy of Nursing. Marie has written many articles on timely nursing topics, in addition to the book The Practice of Primary Nursing. It is truly a pleasure to have such a nursing icon among us. Please welcome Marie Manthey. (applause)

Good morning. Thank you. I can't tell you what an honor it is to be here in this group of nursing leaders who represent the best in the United States. I am absolutely thrilled to be here.

I am coming from another exciting event some of you know about, a program we had in Minnesota last weekend: *A Summit of Sages*. That, coupled with this conference, in the context of some other things that have been happening over the last year or so, have led me to believe that we are indeed in the middle of a sea change in nursing. I'm not sure if sea change is the right word, or if we're talking about the plates under the earth shifting...(laughter)...but nursing is changing. Not just nursing, but the health care system and society are changing in ways, that are going to impact the nursing profession profoundly. I truly believe that some of the barriers that we experienced in the past -- barriers to being the best that we can be, to serving society at the level of capability that we know we have -- some of those barriers are no longer present. The challenge we're facing now is whether or not we have the leadership capability to position ourselves in the health care system and in society to deliver the best that we have.

What is so exciting about this event and *A Summit of Sages* is that they are opportunities for leadership to come together and to talk about nursing. At *A Summit of Sages* there were 350 participants from all walks of nursing leadership positions. We had deans of schools of nursing, we had faculty, we had nurse executives and nurse managers and staff nurses from institutions all over the world. We spent a long weekend together talking about where is nursing going, talking about the function of leadership within the profession, and talking about the voice of nursing and how to make that voice better heard.

One of the speakers at *A Summit of Sages* was Suzanne Gordon, a journalist in Boston who has spent years writing about the nursing profession. She's written a number of books about nursing as well as numerous newspaper articles. She challenges us in ways that I find very provocative about the voice of nursing. It's up to people in leadership positions to find that voice and to begin to speak the truth about nursing. One of the things that Suzanne Gordon has really turned my thinking around about is the issue of our intelligence. You know, we do a good job of talking about what great, caring people we are--the Johnson & Johnson ads, for example,-- it's all about the heart of nursing. What Suzanne provokes us to do is to understand how smart we are, that nurses are smart enough and tough enough to save lives. I encourage all of us who have any kind of a voice to start thinking about how to tell people about the science behind how we care for people.

My topic today is Leadership for Relationship-Based Care. I know many of you have heard me speak over the years about Primary Nursing, in the beginning, and then about leadership, and now about Relationship-Based Practice. This is the evolution of the nursing profession over the past 20 or 30 years. When Primary Nursing first got started at the University of Minnesota hospitals, it represented a dramatic change in the way nurses operated at the bedside. Not only did it represent that dramatic change, but it also provided a lot of information for us to understand the principles of care delivery systems and the impact that those principles have on practice. We discovered that the roles that people are in pretty much determine the way they behave. It was an amazing revelation to me to understand that when you give people authority for decision making, they become decision makers; and if they don't have the authority to make decisions, they don't make them.

And so from the beginning experiences with Primary Nursing, we've found that there are three key elements to providing a professional level of nursing care within the acute care hospital, and these three elements are: clear roles, healthy interpersonal relationships, and adequate and appropriate resources. Roles, relationships, resources: Sounds easy, doesn't it? But those of you who are involved in this work know that these changes are transformational in nature and require exquisitely skilled leadership. These things don't happen by accident. They happen only when leadership has the skills necessary to appropriately structure change. We have a new concept in our work, which those of you who get our book on Relationship-Based Care¹ will see. We call it I_2E_2 , and it's a structure for leadership that we have found is always present where change is being effectively managed. I_2 stands for Inspiration and Infrastructure, the E_2 is Education and Evidence, I_2E_2 ; and to handle a change process using those four elements requires a fair amount of skill.

Roles, relationships, and resources: All I'm going to say about roles is that it is important that there be clarity of responsibility and authority, and that responsibility and authority always be commensurate. If at any place along your organizational structure you have people who have responsibility who either don't know it or haven't accepted it, then they aren't going to be able to exercise legitimate authority. No matter how much you delegate that authority to them, if they don't accept responsibility they're not going to use the authority. So the clear allocation of responsibility that is accepted by the individual, along with the commensurate delegation of authority, is essential to have the kind of role clarity that is required for professional practice.

The term Relationship-Based Care represents a true evolution from Primary Nursing, and I want to spend a few minutes describing Relationship-Based Care. I wrote an article not too long ago called "A.K.A. Primary Nursing"², which acknowledges the fact that the term *Primary Nursing* carries a lot of baggage in some places, and it might be better to have the role called some other name. The important thing is to have the role in place, not what it's called. I believe that Relationship-Based Care is absolutely essential for the nursing profession. If nurses are running around doing tasks every day, they aren't really functioning as professional nurses. If they're not engaged in a relationship, a therapeutic relationship, with the human being who is the patient, then it's not – and to me this has gotten very, very clear – they are not engaged in nursing. Anybody can do tasks, and we need to stop differentiating our hands from others according to the complexity of tasks they perform, because as long as we do that we remain very, very vulnerable to all kinds of changes being imposed from outside. We need to step up to the plate and assume responsibility for managing the care of a caseload of patients over a legitimate period of time. With short-term patients and part-time nurses that legitimate period of time will vary considerably, but there still needs to be Relationship-Based Care in place.

I want to tell you the story of a friend of mine who was a patient in one of our local hospitals. She was admitted at 3:00 in the afternoon to the emergency room with chest pain and shortness of breath. Now you have to know a little bit about my friend. In her mid-fifties, she has a Ph.D. in 17th century English literature with a specialty in John Donne -- "Death be not proud" -- and she was working in a field that had absolutely nothing to do with her preparation. She was working as the director of sales for a dot-com that was going for an IPO, and so she was handling the sales data from hundreds of salesman all over the United States, using metric systems that she knew nothing about. She was way over her head all the time, studying Excel spreadsheets, she was working 12 hours a day. This was an incredibly stressful job, and she felt like she was coping okay, but the pressure, because she didn't have the adequate preparation for what she was doing, was enormous. On the day she was admitted to the hospital they had completed a successful two and a half day sales conference, when salesmen from all over the United States came for the buildup, the hoorah, and she had managed that whole event. It was over with at noon, and it had been very successful. At 3:00 she was admitted to the hospital with chest pain and shortness of breath. I saw her in the ER and they were giving her nitroglycerin, which was relieving the pain, and they had her on an EKG, which was non-indicative of any serious problem. Her enzymes were inconclusive. The chest pain came back after awhile, along with the shortness of breath, and again nitroglycerin relieved it. So it was confusing set of symptoms, and they decided to admit her to a telemetry unit; and while she was there the cardiologist came in, did a physical exam, palpated under her right rib cage and found some tenderness and said, "We'd better do an ultrasound of your gall bladder," which they did at 10:00 on Friday night, the first time the ultrasound was free. Indeed, they found that her gall bladder needed to be removed, and she was scheduled for surgery and then came the ambulatory surgery unit at 8:00 Saturday morning, after which we went to the recovery room, after which she went to the post-op unit, from which she was discharged at 8:00 PM Saturday night.

She was in the hospital from 3:00 Friday afternoon 'til 8:00 Saturday evening, a total of 30 hours; during that time she received nursing care on five different units. I was there, off and on, on every unit, and I'm telling you, I saw the best Relationship-Based Care you could ever want to see. They

weren't calling it Primary Nursing, but that's what was happening. On each unit she was admitted by a nurse who had received a report from the previous nurse, who told them something about my friend Shari and the stress of her job and what had just happened in her life, so that the new nurse had a basis of information about my friend. The new nurse introduced herself, told Shari what her role was, and told her what would happen at the end of her stay and what the nurse's role would be there. There was a contract on every single unit established between Shari and the nurse who was responsible for her care. That is Relationship-Based Care, and this is the type of relationship that we need to be setting up regardless of how long people are in the hospital, regardless of what the situation is. If you're in an ER, you need to know the name of the nurse who's responsible for your care and what that responsibility includes.

Relationship-Based Care, in my opinion, is the absolute foundation for professional practice. And when we talk about healthy relationships, there's two different aspects that are important: One is the therapeutic relationship with the patient, and the other is healthy interpersonal relationship among the colleagues. The culture of the unit is really expressed in the way people treat each other and the type of interpersonal relationships at the unit staff level.

Years ago I discovered one of those immutable truths, that the quality of care is most affected by the morale of the staff, that the morale of the staff determines the quality of care patients are going to have. You can have fat staffing and bad morale, and patients are going to get bad care; and you can have skinny staffing and positive morale, and patients are going to get good care. I have come to believe this and nothing I have ever experienced have shaken this belief. Morale is a function of the way nurses treat each other, the way the unit staff treats each other. It's not a function of what the doctors say, it's not a function of how many bad patients they've caught, it's not a function of the staffing level. It's a function of the way people treat each other, and this is where leadership becomes an exquisitely important element in developing professional practice. It's up to the leader to set the tone, to establish the ground rules for interpersonal relationships at the unit level. We have found that when leaders understand how important this part of their role is at the unit level and have the skills to facilitate healthy interpersonal relationships, the quality of care, which is affected by the morale of the staff, raises up.

You know, nursing is a hard, hard business. We deal with a high level of uncertainty every day. No one really knows for sure what's going to happen in their unit on any given day. You go to work with that kind of uncertainty. We're dealing with human beings who present themselves to us at their highest level of vulnerability. I recently was a patient, twice. I've had two joints replaced in the last six months, and I understand that level of vulnerability and how it affects the way patients interact with the staff--and then we expect the staff to give of themselves. The professional nurses who are in therapeutic relationships with patients are always giving of themselves -- getting too, but mostly they're giving -- and they need be operating within a culture where people who care about them. Healthy workplace cultures have become sort of the direct link from Primary Nursing to leadership to Relationship-Based Care to healthy work environments, and those work environments are most directly affected by the way the staff treats each other. Healthy interpersonal relationships are key, and leaders need to establish the ground rules for those relationships.

Many of you have seen the little "Commitment to My Coworker" cards³ that we produced and continue to distribute throughout the world. These cards contain fundamental, simple, basic ground rules for interpersonal relationships; but I believe they are important. I believe it's important for people in leadership positions to be very clear that they expect everybody on the staff to get along with everybody else, and that if anybody is having a problem with somebody else that they expect them to solve the problem with the person with whom they have it. These kind of simple truths need to be articulated by people in leadership positions all the way up to the top and all the way to the unit level. A vice president needs to have healthy interpersonal relationships with her executive team. If there's anybody on that executive team that is not singing out of the same hymnal, that is not onboard with the direction that the leader is taking that unit or that department, everybody will know it. It's really important that those kinds of situations get dealt with, rather than be allowed to continue to impede forward progress.

Healthy interpersonal relationships at all levels are essential to successful development of professional practice. We work in a high-risk environment; we deal with human beings who give themselves to us with vulnerability at every level of their being, physically, spiritually, emotionally, and mentally; and in order for us to respond appropriately in effective therapeutic relationships at the bedside, the values of healthy interpersonal relationships and an effective organizational structure are essential.

And now the third element, adequate resources. I love the work of Linda Aiken and what she is demonstrating about the impact of resources, and I love her work because it is statistically based. It is the story we need to be telling. What I love so much about what Linda Aiken is doing is that she's tearing a page out of Florence Nightingale's book. Nightingale was a statistician. She understood the value of metrics, and do you know what she said? At one point in her life she said she loved statistics because it helped her see the mind of God. Now I don't get that. (laughter) I never have, but I have such respect for that woman's life that I'm sure she knows what that means. (laughter, applause)

We are all challenged by the research that we're finding -- in the context of everything we know about staffing -- to look at the way we think about staffing. We have some mindset issues about staffing that are pretty self-defeating. I will tell you, I have talked to thousands of nurses, in the United States and in other countries as well. The astonishing thing is that it's all the same all over the world. In the United Kingdom the nurses have exactly the same responses about staffing that they have in the United States.

I do a little experiment with them, sort of like in the Russell Ackoff kind of fantasy. We say your hospital blew up last night, and God says to you today you get to build the hospital new, however you want it to be. God says you can have the number of patients that you want to have, the size units that you want to have, you can have the doctors that you want to have, you can do everything that'd just make it perfect. God says, you're going to be able to do that, I'm giving you that power. God says, you can have as many nurses as you need for all eternity. God says, there's a cornucopia of nurses up in the sky, and all you have to do is pull the chain and I'm going to send nurses down to staff those units for you. (laughter) God says, you're going to have as many nurses

as you need for ever and ever and ever. And then I say to the audience, now let's pretend that we built 25-bed units. Now many nurses are you going to ask God for? What do you think they say? 25. (laughter) And then I say, are they going to work around the clock? And they say, oh, no, 75. (laughter) See, I think this is indicative of a mindset problem.

I do another thing where we say, okay, let's imagine that you have exactly the right amount of help for the amount of work required on your unit today, that there's this magical barcode, a *Star Wars* kind of a wand that the night nurse runs over every patient's bed, and the barcode adds up -- *ch-ch-ch-ch-ch-ch-ch-ch-ch-ch-ch-ch-ch-ch-ch-ch* --, the amount of activities that will be required over the next shift at different levels of skill. Let's say you find out that you're going need exactly this number of RNs, LPNs, and nursing assistants for this time period to take care of this group of patients, and it's going to be exactly the right amount of staff. And I say to the staff, how often does that ever happen in your hospital? And what do you think they say? Exactly right: they say never.

These are indicative to me of mindset problems that we have. Far too often nurses are going to work in the morning being afraid that they're not going to have enough help, that if everybody shows up you're going to pull somebody. Far too often they go home at night anxious and worried, driving home saying, "Oh, I didn't do that. Oh, I didn't do that. Oh, I didn't do that. Oh, didn't do that." (laughter) They open the door, and their latchkey kids are watching television, and these ever-loving mothers say to the kids, "Did the hospital call yet?" (laughter, applause)

This is because we haven't been honest about our workload and its relationship to resources. We have perpetuated the myth that if workload goes up, resources have to go up, and if they don't come, it's a terrible problem. This results in anger and fear. We have nurses who drive to work in the morning afraid they're not going to have enough help, and go home at night angry because they didn't. Nursing isn't the only profession in the world that has more work to do than time available, but it is the only one in the world that hasn't given permission to the professionals -- to the people with the highest license society awards for decision making in that field of activity -- permission to decide what not to do when there's more work to do and time available.

I think we have to do some massive changing of the way we think about staffing and resources. We need to start building into the baccalaureate programs resource allocation realities. Instead of teaching them how to get 15 or 20 or 30 needs for the perfect care plan...(laughter, applause)...that's the beautiful care plan...(laughter)...we need to be teaching them how to identify the most important needs that need to be met within the context of the available resources. (applause) And that includes their own resources, their own time and energy. They need to be able to make the decisions about what things that they need to do and what things other people can do, and to learn how to effectively delegate those things without fear.

Back on the care plan issue for just a minute. I was in Hong Kong a few weeks ago, and they're implementing Primary Nursing in 46 hospitals in the city of Hong Kong. The Hospital Authority makes a decision and it's then implemented, quite different than the United States. They've got 16 hospitals in pilot units, over 57 units a couple of thousand patients. I was visiting a couple of the units and helping them figure out how they're going to go forward with Primary Nursing for the

rest of the system. We were on a psych unit where they've only implemented it partially, for some of the patients. The first question that the nurse manager asked me was, "How do you deal with patients who have had a primary nurse and now it's removed because we need that primary nurse to be with another patient? How do you tell them that they no longer have a primary nurse?" And I said, "Well, I think that's a serious problem. I've never figured out myself how to do that effectively. Why are you only doing some of the patients?" Well, it turns out that they've got this multifaceted, multi-column, splendorous care plan that takes so long that they only have time to be a primary nurse for a certain number of patients." I just loved telling them, "Primary Nursing is not about care plans. Primary Nursing is about a relationship with a patient." It was amazing to me, when I used the words "beautiful care plans" over there they all knew exactly what I was saying. They were striving so hard to have beautiful care plans, because that's what good nursing was supposed to be about.

Along the way, I think it was about 1982, I discovered in my work in Primary Nursing that unit-based leadership was absolutely the key to developing professional practice and Primary Nursing units throughout the country. That's when Creative Health Care Management developed our leadership development program, which is now called LEO⁴. As that work with leadership development evolved, I came to the conclusion that every person within a management role, every person with management responsibilities, has an obligation to become a skilled leader. It is not okay to be a manager and to not understand how to also be a leader.

I have also realized that there are people with leadership capabilities throughout any system and that it's really important for us to learn how to identify the leaders within any group and use that leadership energy. It's a source of energy for change that we need to know how to use skillfully. I have been so convinced for so long that leadership at the institutional level is the best way to develop professional practice and to let the nursing profession assume its rightful role in the healthcare delivery system -- or in the health of society -- that when I read *Code Green*⁵ I became quite depressed. I don't know how many of you have read the book *Code Green*, but it's a story of the merger of Boston Beth Israel and New England Deaconess.

One of the chapters is entitled, "Dismantling the Nursing Department." To my mind, those two hospitals represented some of the very finest nursing practice in the country for many, many years. I knew those leaders, they were my colleagues and friends, and their names were in the book. The story of that merger, which felt so familiar to me because I had been a director of nursing in a merger in the seventies, and then I took over at Yale New Haven, which was an old merger that still hadn't taken place. (laughter) Oh, we actually had two hospitals when I was there, one for the community doctors and one for the university doctors. We had two operating suites, both with neuro-surg units, cardiac surgery units, I mean, absolutely duplication, because they couldn't practice together. And then as a consultant, I have worked with numerous hospitals in merger situations.

So reading about what happened with Beth Israel and New England Deaconess was just heartbreaking for me, and I was just about ready to agree with Suzanne Gordon, who wrote the introduction to that book. In the introduction, Suzanne Gordon said that we could no longer rely on institutional leadership for professional practice, that we probably need to rely on government

regulations, unions, and collective bargaining, to ensure professional standards. I'll tell you the truth, seeing what happened to nursing during the nineties here in this country.

I wrote an article called, "What do Enron and Nursing Have in Common?"⁶ (laughter) – and then reading *Code Green*, I began to think that maybe Suzanne Gordon was right. Maybe there was no way that, at the institutional level, leadership could develop and evolve nursing's practice.

Then one of my colleagues met Diane Anderson, the new Vice President of the merged facility, at an AONE meeting. She came back and said, "Marie, you have to interview her. You *have* to interview her." So I did.⁷ I called her up and we had a tape-recorded interview, and then I interviewed the CEO, Paul Levy, and my heart has changed so completely after interviewing these two people. I now know for sure it's at the institutional level that leadership can develop professional practice. These two people had town hall meetings with the staff for a long time after they both took over. By the way, the CEO, Paul Levy, is not a doctor, he's not an administrator, he's not an accountant, and he's not an attorney. He was on the Board and I think he was doing something like running the Water Department for Massachusetts; but he was on the Board of the hospital and it ended up that he took the CEO position. He and Diane Anderson went out and did town hall interviews and listened to the staff, and then they set up task forces to begin to solve the problems. They have done such a remarkable turnaround that they are acquiring new physicians, they're building new facilities, they've got no turnover, they've redeveloped a professional practice care delivery system. In less than two years there has been a complete turnaround of the story that was told in *Code Green*; and so I know, again, in my heart once more that leadership is the source of energy for developing professional practice. (applause)

There are five criteria that sociologists use to define a profession: identifiable body of knowledge, autonomous decision making, peer review of practice, a professional organization for standard setting, and a system of values so fundamental to the nature of mankind that those who hold those values can be said to profess to them, as in witnessing. We, as a profession, are blessed with a very firm foundation in values. To my mind, we can thank Florence Nightingale, to a large extent, for putting that into our modern nursing consciousness. I have enjoyed very much a book by Barbara Dossey, *Florence Nightingale: Mystic, Visionary, Reformer*⁸. She has provided insight into this woman who brought nursing into all realms of activity, and has instilled in me, great deal of pride in our foundress.

Suzanne Gordon talks about the importance of us talking about our intelligence. Plenty of people know that we are intelligent, that our actions are based on science and evidence. I'm not talking about just turning the patient to prevent bedsores, but why it is that bedsores develop, what is the science behind why we do what we do. As I studied the life of Florence Nightingale, I realized that our profession was founded by someone who was extremely brilliant. Florence Nightingale was an intellectual of a very high level. She wrote and spoke in five languages. She made notes in her Bible in five languages, which I think means that she could think in five languages, because if you're making notes in your Bible, you must be thinking. And she founded our profession on a set of values that we need to be attending to as leaders.

The wonderful thing about leadership energy is that it creates energy. Management allocates energy; leadership creates energy. And what I want to talk about now with you for a few minutes is the leadership requirement for inspiration. We need to learn how to regularly inspire. Inspiration means taking in energy, and we need to have leaders who understand the importance of inspiring the staff.

None of us became nurses because we wanted to own BMWs and live in fancy suburbs. (laughter) Most of us became nurses (or if we didn't begin this way, we had to get there somewhere along the way, or we wouldn't have stayed) because we highly value the notion of one human being helping another. And we live in a world where that is not recognized or valued by the rest of society. We live a world that recognizes materialistic advancement, and in fact, it views ownership of things as a reflection of the quality of a person. We've actually come to believe that people who have more must be better than people who have less. We live in a society that supports competitiveness, the winners are better than losers; supports aggression in business. "Oh, he's an aggressive salesman." "Swim with the sharks." "Attila the Hun." You know. (laughter) And here we are, sort of as goody-goody two shoes, saying that, of all the forms of human interaction, one human being helping another is of highest value.

Nightingale said, "Nursing is a noble profession, but it is up to you nurses to make it noble." I think about that a lot. At first I thought I didn't like the sentence structure...(laughter)...but the more I've thought about it and the more I've said it out loud, the more I've come to understand it's said beautifully, succinctly, and in the best and most strongest way possible. "Nursing is a noble profession, but it is up to you nurses to make it noble."

Now I know for sure that it's impossible to experience the nobility of nursing when the delivery system at the unit level is what we call FRED, frantically running every day. (laughter) If you don't have a delivery system in place that facilitates the establishment of effective therapeutic relationships over a reasonable period of time for a patient's care, then you're not giving the nurses an opportunity to experience the nobility of nurses. I truly believe that every time a nurse walks into a patient's room and interacts with that human being in a way that alleviates pain or increases their sense of comfort, that that is an activity full of nobility and dignity. We need to have nurses who experience that nobility, who acknowledge it, and who are grateful--grateful--for the privilege that they have of the trust society gives to the nursing professional. People come to us with that vulnerability of every level of their being. They are open to us, we get to know patients better than anybody else knows them in many, many respects. You know, it's by no accident that the Gallup poll continues to show nursing as the most trusted profession in the world, year after year after year, except for 2001, when firefighters got that designation.

And yet, we have staff nurses who come to work afraid they're not going to have enough help and go home angry because there wasn't enough help. I give you, the leaders of the profession of nursing in this room today, the charge to not only manage the transformational change processes that are necessary to ensure professional practice in all the settings where patients and nurses are together, for long-term patients and short-term patients; but also, I give you the charge to inspire your nurses, give them permission to understand the nobility and the dignity of their interactions with patients.

You know, there are other values within the nursing profession that we also can attribute to Florence. She didn't believe that people should get better care or worse care by virtue of their ability to pay. This is an important quality that nurses share. I just loved it, when I used to be a vice president and I'd have Mister Got Rocks in the private room down the hall...(laughter)...and I'd go up there on the evening shift and I'd say to the charge nurse, "You know, you've got Mister Got Rocks here and he's on the Board and, you know, he's a great contributor, has an endowment fund, blah-blah-blah, blah-blah-blah, I want you to make sure that he gets really good care." And she'd say, "Miss Manthey, are you saying we're supposed to take better care of that patient than we take of all our patients, huh?" (laughter, applause) And I'd say, "No, no, no, no, no, you know, I know you're going to do a good job with everybody," and I loved that, I just loved that. That's something we can be proud of.

A young graduate from the University of Minnesota was talking about her first year of working at Hennepin County Hospital in the OB department, and how she learned a lot during her education about the different cultures that she'd be taking care of, but what she didn't know she would have to face when she graduated was about the subcultures in America. She told about taking care of a patient who was a prostitute and who was pregnant with twins, and the father was the pimp. This, of course, was an extremely distasteful lifestyle to this small town Minnesota young woman, and she talked about how she struggled with how could she take care of this couple professionally. Thinking about it the night before, in between two days of care, she was able to realize that this was a mother who was losing her babies -- they weren't going to live -- and a father who was losing his babies, and she was able to go into that room and deal with them as mother and father, rather than as people whose lifestyle she didn't support.

I am so proud of the nursing profession for our ability to provide quality care regardless of lifestyle, financial ability, race, color, creed, or any other differentiation within this society. We need to understand that those are the values that this profession is founded on, and to speak to those values to inspire the staff. Nurses need to understand the exquisite privilege we have of being able to interact with people who trust us in a way that alleviates pain and encourages and enhances their sense of wellbeing and comfort.

I am thoroughly convinced that the future of nursing depends on people in leadership positions being able to manage themselves in such ways that they are role models for the staff. One of the things that I learned very quickly in the early days of Primary Nursing was the importance of accepting responsibility for myself, and I want to tell you what that came to mean to me, because I hope it means the same to all of you. I understand now that I am responsible for my own thoughts, feelings and actions, and I can't blame anybody else for the way I think, the way I feel, or what I do. Once I understood that my responsibility is for myself, not for you, but for myself in this life, I immediately became conscious of choice; and consciousness of choice is one of the most empowering experiences a human being can have. It absolutely obliterates any opportunity for victim thinking.

Now as leaders it is absolutely essential that every single person in this room moves themselves to the level of self management where you are accepting responsibility for your thoughts, your

feelings, and your actions. Eleanor Roosevelt said, "No one can make you feel inferior without your consent," and if you find yourself blaming somebody else for what's going on in your life, for the way you feel or what you've done, stop it. Accept responsibility for yourself, and experience the consciousness of choice. In that way you will be embodying the empowerment that staff nurses, that nurses throughout the system need to be learning from people in leadership positions.

The sea change that I think is happening in nursing is coming about for a lot of different reasons, but what I think is happening is that the healthcare delivery system and society as a whole, is coming to understand better than ever before that nursing is a strong and viable profession, and that we have the capacity to deliver much more health care than our current roles and restrictions allow us to do. As we move forward into the 21st century, I challenge us to hang onto those values that Nightingale instilled in us in the 19th century, to make sure that they are the bedrock of nursing in the 21st century, but also to throw off the mantles of victim thinking and shortsighted thinking that marked much of our work in the 20th century.

It is time for us to step up, to begin to articulate clearly who we are and what we can do, to not accept any longer the invisibility of nursing in society, and to do that we must become clear and articulate spokespersons for the profession. I think that the Magnet movement within the United States and throughout the world is going to be a tremendous vehicle for helping us to accomplish that, and I ask each and every one of you here to today to step up to the plate, become an articulate spokesperson for the profession of nursing, and help the world understand what Magnet is. And also what professional practice is all about, and what a tremendous impact we have had and will continue to have and can grow into as we evolve as a mature profession in the 21st century. Thank you all very much. (applause)

Notes:

1. Koloroutis, M. (ed.). (2004). *Relationship-Based Care: A Model for Transforming Practice*. Minneapolis, MN: Creative Health Care Management.
2. Manthey, M. (2003). AKA Primary Nursing. *Journal of Nursing Administration*. 33(7-8):369-70
3. Commitment to my Coworker cards are available through CHCM. Call 800.264.3246 to order.
4. For more information on Leading an Empowered Organization (LEO) classes, call 800.728-7766 or visit www.chcm.com.
5. Manthey M. (2003). What do Enron and nursing have in common? *Nurse Leader*. 2003;(1):33-36.
6. Weinberg, D. (2003). *Code Green: Money-Driven Hospitals and the Dismantling of Nursing*. Cornell University Press.
7. Manthey, M. (2204) Beyond Code Green: The untold story about the Beth Israel and New England Deaconess Hospital merger. *Creative Nursing*, 10:4. 7-12. call 800.728.87766 for a sample copy.
8. Dossey, M. (2000). *Florence Nightingale: Mystic, Visionary, Reformer*. Lippincott Williams & Wilkins.