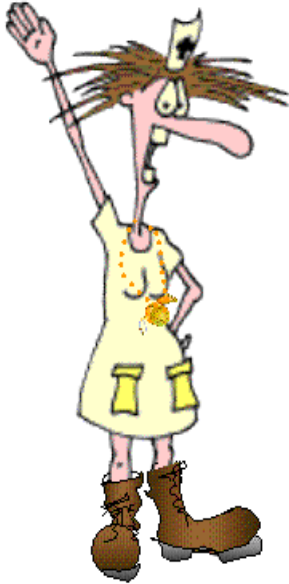


# The Nurse Manager Boot Camp E-zine...

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Tips on Leadership from Abraham Lincoln Himself!



While few times in recent memory have been as difficult for leaders in medicine and health care as they are today, none of us have had it as rough as President Abraham Lincoln: Seven southern states had seceded from the union; Jefferson Davis was sworn in as President of the Confederate States of America; and Congress refused to take any action whatsoever to quell the rebellion—all just 10 days before Lincoln took office. How did Lincoln do it? In his book, *Lincoln on Leadership*, Donald Phillips summarized Lincoln's strategies into several leadership principles:

**1. Persuade people** rather than bury them in statistics. The numbers have to be there, but only *as back up for the stories*. Lincoln told stories -- usually stories that made people laugh -- and his stories always had a point. There is a lesson in here for all of us: one we can use or ignore (to our peril).

**2. Never act out of anger, fear or vengeance.** Pettiness and spite have no place in the successful management of any enterprise.

**3. Get out and meet people.** Some people call this MBWA – management by walking around. The key is that you are seen – and that *you see for yourself* what is actually going on in your unit, department or service. Depending only, or primarily, on the reports of others, however trustworthy, means that someone else is actually managing your area of responsibility.

## What the Books Don't Tell You!

### *Royalty Management: Identifying the Queens*

One of the most difficult, and pervasive problems that literally every manager faces is the 'management of Royalty.' Those are the "Queens" (or Kings) that stir the pot, create chaos, disrupt the teamwork, rule the "kingdom". They are not to be confused with change agents. These folks are not constructive; they are destructive -- to the work of the unit and the morale of their co-workers. As I have traveled around the country, I have found them in literally every hospital, and in every nursing department, and in almost every patient care unit.

Queens are almost always highly clinically competent, which makes them valuable (especially in the eyes of the medical staff). But their competence is more than offset by the damage they do to morale and to staff development. Queens like things to be done their way. If it isn't, someone "pays" – one way or another. Younger, or less experienced staff is afraid to confront them or to flout them for fear of repercussions. Some even become princesses (Queens in Training) to avoid being the recipient of the Queen's disfavor. Often managers are at a loss as to how to handle the problem, and "go along" with the Queens in an attempt to maintain peace. Don't!

The problem with Queens is that they divert attention from patient care by creating an unsettled environment within the work force. In my experience, eliminating one queen is the equivalent of adding 2 FTEs to a unit! In a time of scarce resources, this is clearly an issue to be tackled.

Seen any scepters lately? Stay tuned for next month's tips on overthrowing the monarchy.

*Gail Wolf, EdD, RN, FAAN*

## New Rules to Re-design and Improve Care

The IOM committee on patient safety offers 10 new rules to improve safety in the U.S. healthcare system.

**1. Care based on continuous healing relationships.** Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This implies that the health care system should provide access to care by Internet, by telephone as well as face-to-face visits.

**2. Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

**3. The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them.

**4. Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge.

**5. Evidence-based decision-making.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from place to place.

**6. Safety as a system property.** Patients should be safe from injury caused by the care system.

**7. The need for transparency.** The health care system should make information available to patients and their families. This includes information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

**8. Anticipation of needs.** The health system should anticipate patient needs, rather than reacting to events.

**9. Continuous decrease in waste.** The health system should not waste resources or patient time.

**10. Cooperation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

## Collaborative Law & Dispute Resolution

The adversarial method of resolving disputes in court is frequently criticized as inefficient, costly, and mentally unhealthy for the participants. Mediation and arbitration have been offered in response to the criticisms, and are sometimes used voluntarily, or as required within a contract for services, e.g., in managed care contracts. A new model, collaborative law, is the latest effort to avoid litigation (Grace, 2000).

The key component of collaborative law is the role of the lawyer. In collaborative law, the lawyer serves only during negotiation of a settlement. If a settlement cannot be reached, the lawyer must withdraw and refer the client to a litigation attorney. Also, both parties agree to full disclosure of records and other relevant information.

Stuart Webb, a family lawyer in Minneapolis, Minnesota, developed the idea in the 1990s because of the negative effect litigation was having on divorcing families. He founded the Collaborative Law Institute in Minneapolis. A group of California lawyers has developed a similar approach to resolution of family disputes that they call "collaborative divorce" (Grace, 2000). Mental health, child, financial personnel work with attorneys and the parties to resolve the disputes. The effectiveness of these methods is yet to be tested, but the goals of the new approaches are laudatory .. to shorten the length of the process, preserve the mental health of the families and to reduce financial costs.

Although disputes within families stirred the need for a healthy approach to conflict resolution, malpractice disputes could benefit from this new approach as well. Emotions run high when an adverse event occurs, and negotiating collaboratively to resolve allegations and responses might promote a therapeutic, healing result for all concerned.

Take home message: Nurses need to realize that alternative approaches to conflict resolution exist and may enhance healing, rather than fracturing, relationships.

REFERENCE: Grace, N. (2000). Collaborative law: A new concept in alternative dispute resolution. *NCAWA Quarterly briefs*, 23(2): 3,6.

*Diane Kjervik, JD, RN*

*Editor, Journal of Nursing Law*

# A Model for Ethical Decision-making in Management

Human concerns in management do not vary significantly from human concerns in other endeavors --including nursing. However, the focus and scope of these concerns differ. As a nursing administrator, one is concerned with the efficient, effective and humane delivery of nursing services to all patients in an institution. As a practitioner, one is concerned with the efficient, effective and humane delivery of nursing services to a specific patient or to a limited group of patients. Such differences in perspective may lead to conflicts, particularly if there is not appreciation for one another's legitimate roles and concerns - and relative authority and freedom, or lack thereof. These conflicts can be minimized if, in the sorting out of priorities and ethical quandaries posed by conflicting claims and needs, nursing managers ask themselves the following questions:

**(1) What is actually going on here?** That is, how much factual information is available about this situation, issue or conflict? Which needs are the greatest? Why?

**(2) What criteria should be used to make this decision?** Is it essentially a nursing decision? an administrative decision? Is the problem involved essentially one of policy?

**(3) In this particular instance, who is best qualified to make a decision** --the staff nurse(s), nursing management group, physicians, administrative council?

**(4) Is this decision, in fact, a group decision?** That is, how should the decision be made, individually or collectively? Why?

(5) A fifth question to be asked is, **who should benefit the most** from a particular decision --patients, staff, families, and the institution? Ideally, all should benefit, but in reality a decision may be made at the expense of the others groups.

**(6) How should the decision be implemented?** One major administrative responsibility is to ask and to answer this question. When faced with ethical problems or issues, the nursing administrators' priorities differ from clinicians' not only in scope but also in breadth or inclusiveness. That is, the administrator also must place high priority on the well being of other employees and on the welfare of the institution itself -- not usually areas of high priority for staff

If it is a collective decision, all involved should be aware of several characteristics of group decisions and the group participants' responsibilities in the making of such decisions. In general, participation in group decisions obliges one to submit to the ultimate authority of the group. There are, of course, exceptions to this obligation the exegesis of which is not the subject of this paper. Generally, when individuals consent to participation in groups, they assume accountability both to the group and for the group. That is, as a group member, a person can be called upon to answer to the group for any actions he or she may take that will affect the group. Moreover, as a member of a group, a person is answerable for all actions taken by that group (to the individual(s) most affected by a group decision, to the institution or agency, possibly to statutory bodies and perhaps to society at large).

No group member is absolutely autonomous: the self cannot be allowed "to hold sway" because the group's decisions and actions affect more than the self. In addition, participation in a group requires a person voluntarily to assume accountability to someone or something other than the self. However, because the individual also has assumed accountability for the group, he or she must exercise the responsibilities of freedom within the legitimate structures provided. Therefore, in some instances, it may be necessary for a group member to oppose a group decision. Although non-compliance is not the right of any group member, it may be a duty. The burden of proof, however, lies with the dissenter.

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