

LEADERSHIP

Leading wherever and whenever: Ensuring oncology nurses are future ready

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ABSTRACT

Leadership is demonstrated by oncology nurses every day. Some work in formal nursing leadership roles while others demonstrate informal leadership skills, as part of an interdisciplinary clinical team. As we work to provide exemplary care to cancer patients in an increasingly complex and resource-restricted system, the need for everyone to embrace nursing leadership practices is increasingly important. Formal oncology nursing leaders work to implement changes to enhance and improve the system while informal oncology nursing leaders must participate in that process to ensure their expertise and experience can inform the plan. Through personal stories and reflection, and using a leadership framework, this paper will explore how and why to take the opportunity to lead wherever your oncology nursing work takes you.

When I was asked by the Board of Directors of CANO/ACIO to address the annual conference delegates in a keynote address about oncology nursing leadership, I was stunned. I was absolutely honoured but, at the same time, stunned. Surrounded during my entire career by some of the most globally recognized oncology nurse leaders, I struggled to understand what I could bring to the discussion of leadership. Dr. Linda Watson explained that my experience moving from informal leader, to formal leader and back again (the back again being especially interesting) was what they wanted to hear about. How do you take leadership skills to the point of care? And how can we help every oncology nurse recognize

their role and responsibility to demonstrate leadership wherever they are? Through personal stories and reflection, and using a leadership framework, this paper will explore how and why to take the opportunity to lead wherever your oncology nursing work takes you.

When you think of leadership, what comes to mind? The manager? The educator? The director? The executive leadership at your institution? Yes. But there are others: the colleague you turn to when you need help with that tough IV start, the one who helps calm the waters when busy complex work days lead to escalating tempers and cracks in the team dynamic. Or what about the feeling you get when that certain nurse is going to be in charge for a while and you know that nurse will do a great job to keep things running smoothly and fairly. You have seen, no matter how long you have been nursing, leaders who behave in ways that foster great things from their group, and those who do not. Some leaders are powerful, leaving behind a wide and choppy wake, but they can get things done quickly. Other leaders are softer, but steady, leaving barely a ripple behind while they get things done slow and steady. What type of leader are you?

LOOKING BACK AND AHEAD

My mother was a nurse. Her textbook, *The Art, Science and Spirit of Nursing* (Price, 1954), always fascinated me. I checked back to that text to see if nursing leadership was taught to nursing students in the 1950s. Although leadership per se is not a topic in the book, the changing relationship between doctors and nurses was highlighted. The nurse was described as the hub of the team, bringing together many services in the hospital to ensure best care for patients. The behaviour of

the nurse and the expectation that the nurse would promote in others an attitude of respect and consideration hints at the expectation that nurses were expected to lead by example. The notion that the nurse was modelling behaviour for other hospital staff was clear and the student nurse was instructed to remember this always when at work. Although not yet formalized, the theme of nursing leadership was starting to take shape.

Move decades ahead to the present day. The quadruple aims of healthcare are now widely viewed as the guiding work plan for healthcare institutions. Ambitious and broad, the four aims include improving population health, reducing costs per capita, improving the patient experience, and improving the work life of healthcare providers (Reid Ponte et al., 2016). These goals are made even more difficult in the oncology setting where the increasing incidence of cancer and numbers of cancer survivors place growing demands on resources. The speed at which new treatments are being made available is escalating. Many new cancer treatments are designed to be ongoing until disease progression, making cancer a chronic disease that requires new ways of thinking about planning and providing care. Formal leaders are faced concurrently with unprecedented financial constraints and demands to deliver on quality indicators across all domains of the healthcare system. Quality councils, quick tests of change and the rapid implementation of those changes have become part of our daily work life. Formal leaders cannot make it happen alone, our success in providing the best possible care depends on our collective leadership efforts.

“Nurse leaders and clinicians in oncology settings are challenged to anticipate future trends in oncology

care and create a culture, infrastructure, and practice environment that supports innovation, advancement of oncology nursing practice and excellence in patient and family-centred care. Performance metrics assessing key processes and outcomes of care are essential to meet this challenge (Reid Ponte, 2016, p. 110).

As a young oncology nurse, I never considered taking on a leadership role. I loved my job and the satisfaction I got by providing nursing care to cancer patients and their families. I was not searching to make changes. One of my favourite responses to corporate communications was, “I honestly don’t care; I just care about looking after my patients”. In 1994, our local CANO/ACIO chapter was holding its annual meeting. I had just become a member, so I attended the meeting to learn more about the organization. I left the meeting as the next chapter president because no one else was willing to run in the local election. I can think of many other examples where I found myself in leadership roles by acclamation; coordinator of the Breast Disease Site Team in our cancer program and then Chair of the Breast Disease Site Team, Vice President/President of CANO/ACIO, and the Chief of Nursing Practice for the Cancer Program at Hamilton Health Sciences. Each and every leadership opportunity I have had presented itself to me in a setting where no one else wanted to do it. My professional life could have looked very different with competition in the mix. I have learned the power and possibility of saying “yes” and it is a pearl I hope to pass on.

FORMALIZING LEADERSHIP PRACTICE

I was very fortunate to attend the Dorothy Wylie Nursing Leadership Institute (now called the Dorothy Wylie Health Leaders Institute) in 2007. Although I was working in a formal leadership role at that time, my director recognized the value of honing my leadership skills further, formalizing my leadership instincts into thoughtful leadership practices that would give me the tools to lead change implementation in our cancer program. The backbone

of the training was *The Leadership Challenge*, a book that describes five exemplary leadership practices that were observed by Kouzes and Posner (2002) when they set out to understand common patterns of action taken by all types of people when they are demonstrating great leadership. Ten years later I still think of these behaviours when I am struggling to have an impact in a difficult situation. I also think about them when I see great leadership in others. It is happening all the time at work; our challenge is to pay attention and watch it make ripples.

The first leadership practice requires leaders to model the way for others. It involves clarifying our own values and being clear in the ways we express our ideas and our feelings. Dr. Margaret Fitch demonstrates this aspect of leadership in her work as a formal oncology nursing leader. Her research focuses on supportive cancer care with an emphasis on understanding patient perspectives. She brings that knowledge to nurses in a variety of ways so that it can be applied in practice. As CANO/ACIO’s first elected president from 1986–1989, she demonstrated exemplary leadership to a young organization that required her quiet confident vision, her absolute commitment to oncology nursing, and excellence in supportive care practices. She is now the Editor-in-Chief of the Canadian Oncology Nursing Journal (CONJ), supporting young nurses to publish their work and modelling the way by example through her wide and varied publications.

This leadership practice is also demonstrated by informal oncology nursing leaders. A young nurse I work with named Gloria has gained much knowledge about malignant hematology that she applies in practice. She models the way for others by asking questions that are thoughtful, looking for meaning and scientific explanations to tie to her clinical assessments. She asks those questions at the nursing station while others gather around and listen and pipe in. She is a resource to others, but never stops looking for ways to enhance her own knowledge base.

The second leadership practice

requires leaders to inspire a shared vision. It involves envisioning the future in such a way that you can inspire others to see it too, enlisting the team to pull together in the same direction to try to reach that future state. Esther Green was the president of CANO 2001–2003. She has contributed her expertise to the Boards of CAPO, ISNCC, CANO, and CPAC, all with a vision towards excellence in oncology nursing practice in Canada and around the world. To inspire that excellence, she consistently focuses on sharing data about the patient experience to help oncology nurses realize the power of symptom assessment and intervention.

This second practice is also demonstrated by a young nurse who recently returned to her home in Senegal after working in Ontario and completing her Masters studies. Yayra led an ambitious project to implement the Synergy Model (Edwards, 1999) on the in-patient hematology unit at Hamilton Health Sciences. The model requires the scoring of each patient related to their stability, complexity, ability to perform self-care and predictability. In addition, each nurse performs a competency self-assessment using the CANO/ACIO competencies. With these metrics, a staffing model matrix was created to ensure nursing assignments take all elements into account. Gaining the support of staff and ensuring sustainability were big challenges. Yayra’s consistent communication about how the future state would support all nurses across all competencies was an important component. The model has been very successful and is now being implemented across the organization. Yayra and her team won the Canadian Blood and Marrow Transplant Group poster award in 2014. (Editor’s Note: See Yayra’s publications about her experience implementing the model in CONJ, Volumes 27(4) and 28(1).)

The third leadership practice requires leaders to challenge the process. It involves searching for opportunities to be an agent for change, to identify ways to change, grow and improve. Dr. Dawn Stacey currently sits on the Board of Directors of CANO/ACIO as the Director at Large

(DAL)—Research. She is also Director of the Patient Decision Aids Research Group at the Ottawa Hospital Research Institute where her research program is focused on advancing the science of knowledge translation to patients. The overall goal is to understand, measure, and evaluate the effectiveness of knowledge translation interventions for patients and evaluate strategies to enhance patient engagement in shared decision making. She and her team challenge us to explore new ways to coach patients and families about making healthcare decisions. In a culture where the health care professionals historically made most of the choices, Dr. Stacey's work is a great example of challenging the system. Her work is widely cited. In fact, she earned the distinction of having her Cochrane systematic review cited more than any other review in 2015. This suggests uptake of the work and confirms that others also recognize an opportunity for change.

This third leadership practice is also demonstrated by a Nurse Practitioner (NP) in our program. Kari Kolm took the lead on an initiative aimed to introduce an NP role in our hematology day services area. She explored the current care delivery model, consulted stakeholders and identified the priority gaps in the current care delivery model. Guided by an evidence-based framework (Bryant-Lukoskus & Dicenso, 2004), she successfully introduced the NP role in day services with a clinical focus on Allogeneic stem cell transplant patients less than 100 days from transplant, leukemia patients post consolidation chemotherapy and outpatient autologous stem cell transplant patients. Kari is a great example of being an agent for change.

The fourth leadership practice requires leaders to enable others to act. Through attention to collaboration it involves finding ways to put others in the best situation to strengthen their own skills. This enables others to help to maximize the team's capacity to do great things. Two oncology nurse leaders come immediately to mind. Dr. Denise Bryant, well known around the world for her evidence-based approach to the implementation

of advanced practice nursing roles, enables others to act through her consistent and thoughtful approach to team building (Bryant-Lukoskus & Dicenso, 2004). She involves broad stakeholders in her projects to ensure a depth of understanding about the impacts of the work and, in doing so, she enables those partners to take change back to their own work areas.

The final leadership practice requires leaders to encourage the heart. It involves a special effort to recognize the work of others and how they contribute to the accomplishments of the team. This type of action creates a high morale that can be sustained in challenging times. Dr. Linda Watson is the lead for person-centred care at Cancer Control Alberta. Her research has focused on the lived experience of being diagnosed with incurable cancer and those diagnosed with multiple cancers. Her work challenges us to find new ways to support this group and make them feel less isolated and less different from the rest. When she talks about her research and her interviews with participants it is clear to see her heart is fully invested in the work. She weaves together her own life experience and those of the patients she has studied to broaden our understanding and teach us something new. As a CANO/ACIO leader, her passion for cancer nursing is framed up in her words, her actions and her energy. She has a vision for oncology nurses that puts us right at the table where decisions are made. She challenges us to speak with a consistent voice and to be recognized as opinion leaders and clinical experts.

Another example of the fifth leadership practice involves someone who is not a nurse, but leads nurses with tremendous heart. Georgia is a clinical manager in the hematology program in Hamilton. She took on the in-patient manager role during a time of transformational change. In a physically new space, two units from different campuses of the hospital were being brought together to form a new team. The units had much in common, but there was much that also made them different. A rocky time was anticipated as we moved forward with the

plans. As she was not a nurse, I wondered how she could possibly help get us all pulling together in one direction when the subtle differences in practice between the two nursing groups might not be obvious to her. She encouraged the hearts of the staff in so many ways. Emails would pop up unexpectedly praising staff when she observed leadership behaviour or when she saw examples of exemplary team work. Every Nurses Week she created postcards for the staff using phrases from the many thank you notes she received from patients and families as the message. She always added her own quiet wisdom in one corner for us to reflect on. She made every individual feel valued and she made us strong, as a team.

THE STAKEHOLDER AS LEADER

In season four of the HBO adaptation of George R.R. Martin's wildly popular story, *Game of Thrones*, Tywin Lannister's grandson Tommen is about to become King after his brother's sudden death. Tommen will soon sit on the Iron Throne. He is young and inexperienced. Tywin asks him, "What makes a good King?" Tommen grasps at the answers he thinks his grandfather wants to hear; holiness, justice and strength are all offered up as possible components of great 'kingliness', but Tywin swats them all down with quick examples of why each answer misses the mark. Finally, Tommen decides, wisdom. Wisdom is needed to be a great king. Tywin is pleased. "A wise king knows what he knows and what he doesn't. Your brother was not a good king, your brother was not a wise king. A wise young king listens to his counsellors and heeds their advice until he comes of age. And the wisest kings continue to listen to them long afterwards" (Home Box Office, 2015).

If we were to put a modern-day healthcare label on this lesson it would likely be about bringing stakeholders together to have input and an opportunity to advise formal leaders, as they work to meet the quadruple aims of healthcare. Bringing stakeholders together and synthesizing their input can be time-consuming and can make

moving forward seem very complex. The price of not including those stakeholders, however, can be very high. Without taking time to compile the feedback and advice of those affected by the work plan, the leader risks missing key aspects that could, ultimately, have a negative impact on implementation outcomes. Formal leaders need to involve stakeholders in planning change; stakeholders need to participate in the process in thoughtful ways to maximize opportunities for success. I think back to my days as a young nurse when I ignored requests to join committees and scoffed at the questionnaires that came my way asking for feedback. I was there to care for the patients, I had no time to participate. Now, with years of experience behind me, I can see that to provide the best care for those patients I need to participate as a stakeholder whenever I can. I must ensure that my impact can be felt not only at the bedside, but also in the system that supports that bedside care. Whether seeking out stakeholders as a leader or being sought after to be the stakeholder, never underestimate the power of that collaboration.

EVERY NURSE IS A LEADER

The importance of the notion that every nurse is a leader is not new, but it is gaining recognition. The Canadian Nurses Association has a position statement on Nursing Leadership that is sweeping and includes nurses in every setting of practice. The collective efforts of nurses demonstrating leadership benefits patients, teams, organizations and the broader healthcare system. Those efforts make ripples that we must keep creating to provide care to patients in these very complex times.

Canadian nurses in all positions must develop and exert leadership – from the enthusiastic student to the competent professional clinician, from the excellent team member to the senior executive, and from the novice researcher to the most experienced educator (CNA, 2009).

More recently, CANO/ACIO published its own position statement about oncology nursing leadership. Within the document the responsibility for

individual oncology nurses to learn and demonstrate leadership is emphasized, but also a directive to academic programs, cancer care institutions, and provincial and national professional nursing organizations to make leadership training and development a priority (CANO/ACIO, 2016). Position statements are tools we can all use locally to help embed a leadership culture at work. They can be used provincially and nationally to ensure broader planning for the development of nurse leaders. Position statements can be powerful, but only if they are widely used, woven into strategic planning and policy development. Don't leave them on the webpage, launch them into life.

IT'S PERSONAL

Although I have had tremendous opportunities to hold formal oncology nursing leadership roles, I now find myself back at the bedside. Working as an NP on a busy malignant hematology/stem cell transplant unit has given me the opportunity to provide advanced oncology nursing care to some of the sickest patients within our system. My mind is challenged with planning medical care for complex situations, my communication skills are stretched, as I try to walk patients and families through heart-wrenching decisions about treatment and goals of care. I work within a broad interdisciplinary team where everyone is expected to use their leadership skills to solve problems big and small. I continue to add new skills to my leadership toolbox and I feel very fortunate to work in an environment where the notion that 'every nurse is a leader' is lived out actively.

My decision to move back to a clinical setting was not an easy one, but it was right for me. As the Chief of Nursing Practice for our cancer program I had learned so much about myself and the unimaginable complexity of our healthcare system. It was a tremendous experience. After four years in that role I found myself yearning for contact with patients. It started out as a little floating idea that would come to my mind only occasionally. As time passed the draw became more powerful and I would daydream about the

weight of my stethoscope and how it felt around my neck. As our organization planned to transform hematology services, I co-led the planning for the new nursing model, which included everything from the documentation and forms to the cross training that would be needed. By the time the changes were being launched I knew I wanted to work in that new program in a clinical capacity. Nursing is a career that provides wonderful opportunities to try new things. Seven years later I know that for me the decision was a great one.

As I thought about how to finish my leadership message to my CANO/ACIO colleagues I was searching for a unique idea, something that could support their work and personal life. I found it in the *Toronto Star*. An article by Neil Pasricha (2016) described the *Ikigai* model, the Japanese concept meaning 'a reason for being'. The belief centres on the idea that if you can bring together what you love, what the world needs, what you are good at, and what you can be paid for, then you will be energized, happy and content in life. In Japan, there is no word that means "retired". There is only the belief that the balance of the four concepts will place you in the world in such a way that your passion, mission, vocation, and profession intersect. Once this is achieved, retirement is not required. As one moves toward the centre of the model, weakness in any of the four domains can drag us into areas of challenge; delighted but not wealthy, excited but uncertain, satisfied but feeling a bit useless or comfortable but feeling a sense of emptiness. The challenge for us all is to be self-aware in order to continually move with purpose to the centre. That may involve big changes or small tweaks, but the key is to keep checking in and correcting course as best we can. Interestingly, studies of Japanese people with an *Ikigai* suggest they enjoy a longer average life span, and report higher levels of health and lower levels of stress. I keep it on my bulletin board to remind me where I'm headed.



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