© 4khz/DigitalVision Vectors/Getty Images.

Ethical Leadership by Advanced Practice Nurses

Pamela J. Grace and Nan Gaylord

A good leader inspires people to have confidence in the leader, a great leader inspires people to have confidence in themselves.

—Eleanor Roosevelt

Introduction

Nurses have responsibilities for individual and societal health. These responsibilities are to further the profession's goals of promoting, protecting, and restoring health. Nursing has a central unifying focus on these goals that is evident in the discipline's collective and historical literature (Willis et al., 2008). This focus is primarily on humanization in the context of a person's health needs throughout their lifespan. Nurses over the decades and across nations have been concerned with advancing the health of their societies in the face of tremendous obstacles. These obstacles include the lack of respect accorded to women, racism, dehumanization of the poor, expediencies of war, and ignorance of (or disregard for) the roots of ill health in societal conditions. Pioneering nurses recognized the deeply entrenched nature of many healthcare problems in the organization of society and the special interests of those in power and were concerned enough to marshal political support for change using formal and informal knowledge, skills, and political savvy. Many of these nurses exhibited a courage that put them at risk.

The fact that that almost all of these leaders were women at a time when women's views were not taken seriously makes their successes even more remarkable. How did they do it? What motivated them? Most importantly, what can be learned from their leadership, as well as from new understandings and philosophies of leadership, in order to empower modern-day advanced practice nurses (APNs) in their desire to enable good practice? Nursing is no longer essentially a female profession;

167

males are becoming nurses in increasing numbers including at the APN level (U.S. Bureau of Labor Statistics, 2020), contributing to the diversity of the profession. Nevertheless, furthering nursing's purposes in contemporary healthcare environments requires constant efforts and solid leadership skills. APNs should not necessarily subject themselves to the sorts of serious risks that some of their predecessors did; however, among other things, the APN role is a leadership role. APNs can envision and address needed changes in the immediate context of care or in broader environments including the healthcare delivery system, and calculating acceptable levels of risk is an inevitable part of their decision-making process.

This chapter provides some definitions of leadership that are pertinent for meeting the professional responsibilities of APNs regardless of their role (direct or indirect patient care). It discusses characteristics needed for facilitating nursing goals, including skills of collaboration, communication, mediation, and where necessary, referral. Several types of leadership are explored and related to the essentials of advanced practice, as delineated specifically in the United States (American Association of Colleges of Nursing [AACN], 2011; Zaccagnini & White, 2011), and explicitly as well as implicitly in other countries where the APN role has been developed (International Council of Nurses [ICN], 2020; Pulcini et al., 2010). Although advanced practice roles are relatively new in terms of the development of the broader nursing profession, evidence supports the increasing need for nurses who are well educated, skillful, knowledgeable, and motivated to meet the healthcare needs of their populations (Aiken et al., 2003; Benner et al., 2009; Dyess et al., 2016; Edmonson, 2010; Institute of Medicine [IOM], 2011; ICN, 2020). Adding to the groundwork laid by the IOM report in 2011, the National Academies of Sciences, Engineering, and Medicine's (2021) new report states that only by strengthening nursing's capacity and expertise will the goal of health equity in the United States be actualized. Finally, because it is critical that APNs advocate for justice in health care and in healthcare access, and that they influence policies that negatively affect their populations, some past and current projects of pioneer APNs are highlighted and useful leadership strategies are discussed.

Leadership Defined

Leadership has been defined as moving a group of persons toward a common goal. Leaders establish a direction and influence others to follow that direction; they motivate people toward a shared goal (Curtis et al., 2011; Sullivan & Garland, 2010; Weihrich & Koontz, 2005). This ideal of movement toward common goals is, in a sense, what distinguishes leadership from management. Leadership is not so much a characteristic as a group process. In the process the leader is able to persuade, by various means, the assistance of others to meet a particular goal (Chemers, 2001). Characteristics of the leaders include the ability to develop group relationships, understanding of mutual interest, enthusiasm and zeal for achieving the goal, and capacity to manage resources facilitative of meeting the goal (Chemers, 2001).

Many types of leadership have been described in the literature. Two major types derived from studies are transactional and transformational leadership, and there are elements of overlap between the two. Different leadership styles may be successful depending on whether there is a specific task that has to be completed

or an ongoing process of change. For example, elements of transactional leadership may be needed to achieve a task within a process of transformational leadership for change.

Transactional Leadership

Transactional leadership is perhaps most reflective of many contemporary institutional management practices. It can be conceptualized as a bartering system in which one person has more power in the process than others. There are three discernible styles of transactional leadership as discussed by Howell and Avolio (1993). In one scenario, the leader rewards participants for a job well done—contingent leaders. In a second, the leader sets the terms and rules and takes to task those who do not perform well—active leadership. In a third, the leader does not set the rules but expects certain outcomes, passively watches what is going on, then when things go wrong takes remedial actions. Criticisms of transactional leadership include the idea that it is task oriented rather than visionary (Howell & Avolio, 1993; Murphy, 2005).

Transformational Leadership

Transformational leadership is aimed at change. The leader has a vision or mission to achieve certain goals. To reach those goals, the assistance of others is needed (Burns, 1978). Initially these others are followers in the sense that they are persuaded that the leader's goals are both worthwhile and of interest. "Such leaders energize and motivate their followers to achieve their goals, share their visions, and embrace empowerment" (Grimm, 2010, p. 76). Several characteristics have been noted as important for effective transformational leadership: (1) Transformational leaders have charisma—others are fascinated by them and inclined toward their ideas; (2) they are self-motivated in relation to their goals (internal locus of control) and inspire others accordingly; (3) they are intellectually curious and willing to challenge assumptions or be challenged; and (4) their attention is individualized and focused on the needs of followers. They act as mentors and coaches (Chemers, 2001; Grimm, 2010; Judge & Piccolo, 2004; Murphy, 2005).

Characteristics of Effective Leadership

Certain leadership traits are found in many good leaders. Kirkpatrick and Locke (1991) identified six core characteristics that the majority of effective leaders possess:

1. **Drive**—Leaders are ambitious and take initiative.
2. **Motivation**—Leaders want to lead and are willing to take charge.
3. **Honesty and integrity**—Leaders are truthful and do what they say they will do.
4. **Self-confidence**—Leaders are assertive and decisive and enjoy taking risks. They admit mistakes and foster trust and commitment to a vision. Leaders are emotionally stable rather than recklessly adventurous.
5. **Cognitive ability**—Leaders are intelligent, perceptive, and conceptually skilled but are not necessarily geniuses. They show analytical ability, good judgment, and the capacity to think strategically.
6. **Business knowledge**—Leaders tend to have technical expertise in their businesses.

In addition to these characteristics, the nature of the APN role inevitably also requires well-honed communication and mediation skills. Communication skills are needed for the comprehensive and appropriate exchange of information, and mediation skills are needed to offset conflicts caused by individual personality and perspectival differences within a group, especially a multidisciplinary group. Interdisciplinary collaborative efforts require that all members of a working group have their perspectives and ideas heard. This means drawing out the voices of the reticent and restraining the input of the overly insistent in a respectful and dignity-preserving way. This facilitates collaborative efforts that are egalitarian (Grace et al., 2007). Other commentators (Grimm, 2010; Lachman, 2007) on leadership for nursing purposes have added the characteristic of moral courage. Moral courage is a necessary characteristic of nurse leaders who "hold true to their beliefs and convictions" (Grimm, 2010, p. 75) even when it is risky to do so. However, the risks taken are calculated and rational. Moreover, leaders have "ethical fitness," meaning that they reflect on the values and beliefs that underlie their own thoughts and actions with the intent of understanding prejudices and biases and accounting for them.

The Goals of Nursing: Advanced Practice Leadership

Throughout this text, the responsibilities of APNs are described as firmly grounded in the idea that first and foremost an APN is a member of the nursing profession and bound by the code of ethics of the profession. Codes of ethics are developed by the profession as public articulations of the services provided and the expected conduct of nurses in the course of their nursing work. Although the nursing bodies of many countries have developed their own country-specific codes of ethics, the nursing organizations of these countries also had input in and affirm the ICN's code of ethics (ICN, 2012). The internationally specified goals of nursing are to promote health, prevent illness, restore health, and alleviate suffering (ICN, 2012). Meeting these goals for individuals and groups may require anticipatory proactivity (analyzing the status quo or proposed policy changes for their likely effects), ethical perception or discernment (determination that things are not right and why), and moral agency (actions toward change). Every nursing action taken should be aimed at furthering one of these nursing goals for an individual, a particular society, or sometimes on an international level (as in nurses involved with global issues). When working conditions, the environment, or other influences block the ability to further these goals, nurses have further obligations (Grace, 2001). At the APN level, these responsibilities include ethical leadership for change. Ethical leadership by the APN means that they use knowledge, skills, and influence to lead a group of persons (perhaps other nurses or perhaps an interdisciplinary group) toward a shared goal of improving an aspect of health care or healthcare delivery. Many experienced and thoughtful nurses without advanced preparation have proved themselves to be effective leaders—changing practice and environments, and influencing health policy—but APNs are especially well prepared to serve as leaders. The ICN's nurse practitioner/advanced practice nursing network has recognized some unifying aspects of the role internationally:

- Integrates research, education, practice, and management
- High degree of professional autonomy and independent practice

- Case management/own case load
- Advanced health assessment skills, decision-making skills, and diagnostic reasoning skills
- Recognized advanced clinical competencies
- Provision of consultant services to other health providers
- Plans, implements, and evaluates programs
- Recognized first point of contact for clients (ICN, 2020)

Though not listed explicitly, these role expectations clearly depend on leadership abilities. Advanced education is widely recognized as critical for the APN role.

The Doctor of Nursing Practice

In the United States, there has been a recent drive to educate APNs at a higher level. Initially the goal was that all master's degree programs would convert to the Doctor of Nursing Practice (DNP) degree by 2015. The DNP degree is distinguished from a research doctorate in that it is aimed at preparing practitioners to provide institutional leadership and also serve as educators rather than researchers, although they may still be involved in research. The DNP was formally approved by the AACN in 2004, as of last account (AACN, 2020a):

- 357 DNP programs are currently enrolling students at schools of nursing nationwide, and an additional 106 DNP programs are in the planning stages.
- DNP programs are now available in all 50 states plus the District of Columbia. States with the most programs (more than 10) include California, Florida, Illinois, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, and Texas.
- From 2018 to 2019, the number of students enrolled in DNP programs increased from 32,678 to 36,069. During that same period, the number of DNP graduates increased from 7,039 to 7,944.

The focus of the practice doctorate is to improve outcomes "for individuals or populations, including the direct care of individual patients, management of care for individuals and populations, administration of nursing and healthcare organizations, and the development and implementation of health policy" (AACN, 2004, p. 1).

The DNP degree is controversial, having both critics and supporters. The "pro" positions assert that added education helps nurses fill certain gaps or shortcomings in healthcare provision. Magyary and colleagues (2006) assert that the existence of a DNP degree is very important in that it will equip nursing leaders and managers with the wherewithal to critically question practice status quo and underlying assumptions in order to influence future practices. To this end, the degree includes additional courses in leadership, management, financing, health informatics, and policy (AACN, 2006; Rodriguez, 2016). A major focus is on improving health outcomes and engaging in practice improvement projects. Additionally, DNPs are able to fill clinical faculty positions (Bellini et al., 2012). In the United States, there is a serious shortage of qualified faculty (AACN, 2020b). Moreover, it is thought that this advanced education will remove barriers to autonomous practice for nurses with advanced knowledge and skills. One other argument is that nursing master's degrees are already very course-heavy, beyond that of almost any other academic master's degree, because of curricular and clinical practice requirements; thus, it is not a very big step to add a few more courses that would put the DNP in line with other professional practice doctorates such as pharmacy and physical therapy.

The "con" arguments are from various sources both within and outside the discipline. The medical community has been fairly vocal in its opposition in the media and in academic journals. There are worries that the DNP role will increase confusion for patients, as nurses' roles and physicians' roles are more closely interactive than those of other professions (Miller, 2008). Additionally, nurse scholars worry that these APNs will lose their focus on nursing goals. Concerns about interprofessional conflicts include the deleterious effects on patient care and collaborative relationships, which are essential for projects that require both nursing and medical knowledge for their success (Miller, 2008).

While it is important for U.S. APNs to understand the issues related to the DNP so that they can discuss them in interdisciplinary forums, the most important point for any nurse who is working in an APN role is to stay mindful of the fact that it is a *nursing* rather than a medical role and, as such, to be guided by nursing's perspectives and goals regarding human health. Moreover, the leadership responsibilities that accompany these roles mean that APNs may need to help and collaborate with others in order to envision good practice and work toward good outcomes (Rodriguez, 2016). In the inevitably interdisciplinary settings where advanced nursing is practiced, staying focused on nursing goals and perspectives may be the most difficult task. There will be many distracting influences. Another difficult task is articulating to others what it is that nurses bring to patient care and policy discussions that is different from, and complementary to, the contributions of allied health professionals and physicians (Grace et al., 2007).

The Institute of Medicine's Report

In the United States, an exploration of the status of nursing commissioned by the IOM, an independent, nonprofit, multidisciplinary organization, resulted in the report, *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2011). The report emphasizes the importance of the profession to the nation's health. In the preface it is asserted: "[W]e believe nurses have key roles to play as team members and leaders for a reformed and better-integrated, patient-centered health care system" (IOM, 2011, p. xii). A summary of the report (IOM, 2011) outlines four key messages; two of them are especially focused on advanced practice. Key Message #1 contends that nurses should be able to practice to the full extent of their education and training. More than a quarter of a million nurses are now educated at an advanced level. Thus, legal restrictions placed on nursing practice by individual states should be questioned. Leaders in nursing are called upon to advocate and lobby for state boards of nursing and legislatures to remove practice restrictions imposed by other health professionals. Key Message #3 argues that nurses should be considered full partners with physicians and other health professionals in redesigning health care in the United States. Full partnership implies equality of voice and influence. That is, nursing's perspective on the health of persons should receive parity of expression and consideration in multidisciplinary assemblages.

The second report from the National Academies of Sciences, Engineering and Medicine (2021) emphasizes again that nursing leadership is in an ideal position to further individual and societal health. Moreover,

> Nurse leaders have a responsibility to address structural racism, cultural racism, and discrimination based on identity (e.g., sexual orientation,

gender), place (e.g., rural, urban), and circumstances (e.g., disability, mental health condition) within the nursing profession and to help build structures and systems at the societal level that address these issues to promote health equity (Conclusion 9.4 of the report).

In order to lead effectively in improving health and healthcare institutions we need to value community and public health nursing, transform nursing education, develop nurse moral agency, lift nurse practice barriers, and prepare nurses to respond to disasters and public health emergencies. A framework for developing and enacting nursing leadership is found on page 279 of the report (National Academies of Sciences, Engineering and Medicine, 2021). Essential aspects of nurse leadership include the following domains: nurses leading self, leading others, leading health care, and leading beyond health care. As discussed earlier, the DNP is one movement aimed at enhancing nursing practice and leadership. Important aims of the DNP are to make visible the particular perspective and expertise of nurses by teaching leadership skills and encouraging leadership opportunities.

Enhancing APN Leadership

There are ongoing questions about who is or can be a leader. Some people are obvious leaders; some might even say they are "born leaders." But the question remains whether leadership is possible for all APNs. The answer has to be yes. Leadership is possible for all, but the level of leadership may differ depending on setting and goals. Earlier a reminder was given as to the nature and extent of APNs' responsibilities for individual and societal health. This is what makes all leadership ethical. APNs must have some capacity for taking the lead in furthering these goals. Otherwise, they cannot be said to have ethical responsibilities. In order to be held ethically responsible, choices in action must exist. Many, many books have described leadership models and leader characteristics or traits. Seminars to develop leaders are offered within institutions, outside institutions, sometimes even by employers or contracted by employers for their employees. Nurses should avail themselves of opportunities to develop and refine their own leadership skills and behaviors. Arguments about whether leadership skills can be learned or whether natural personal traits are required for leadership continue; however, leadership behaviors that are regularly practiced can become well-honed skills, just like other skills developed for nursing practice. Case examples of leadership behaviors and the education and skills underlying them are given shortly.

APN Leadership Expectations

This next part of the discussion assumes that leadership by APNs is both an expectation and an ethical activity. For nursing, all leadership activities have ethical content. They are directed toward the ultimate goals of protecting and promoting health and relieving suffering using nursing's perspectives, whether at the individual level or at unit, clinic, or health-policy levels. In Canada an encompassing framework for advanced practice nursing has been developed and is titled: Advanced Practice Nursing: A Pan-Canadian Framework (Canadian Nurses Association, 2019). Expectations of this role include using advanced knowledge from a variety of areas to improve healthcare for persons using a nursing perspective. They are

expected to use their knowledge and advanced skills to improve healthcare out-comes and contribute to cost-effective care. Additionally, they to provide leadership for point-of-care nurses, peers and allied health colleagues, collaborating with them to influence needed policy changes.

To insist to the new APN graduate that leadership is an expected responsibil-ity within the role may be unrealistic initially. The new graduate in a direct patient care role is orienting to a new clinical environment, with many processes and ex-pectations to master. One antecedent of good leadership is an understanding of the environment. However, once an APN has been in the role for a period of time, clinical or policy concerns become evident. It is at this time that leadership skills are needed to implement the needed changes. The Pan-Canadian Framework (2019), recognizes the problem that, novice APNs will not be able to fulfil all aspects of the role initially but with good mentoring and employer support they can strengthen their skills. Sherman (2013), however, encourages younger nurses to seek leadership opportunities and describes a competency model used for nursing leadership development. The Nurse Manager Leadership Partnership's (NMLP) Learning Domain Framework was developed by the American Organi-zation of Nurse Executives, the Association of periOperative Registered Nurses, and the American Association of Critical-Care Nurses. The model's key domains include the science and art of leadership and the development of the "leader within." Shirey's (2007) discussion accords with Sherman's argument. She likens leadership development to that found in Benner's work on the development of nurses from novice to expert that occurs over time. However, Shirey's leadership development model maintains that the successful attainment of leadership com-petencies is more important than years of experience. Leadership abilities are de-veloped on the same continuum from novice to expert, and leaders are frequently in roles where they have no particular leadership competencies. To progress to competence, these leaders need access to leadership learning opportunities or to identify mentors who can guide them. The American Nurses Association (2013) is building a cadre of nurse leaders through its Leadership Institute, which offers a series of five webinars (interactive conferences). This institute covers five key areas: strategic thinking, results-oriented leadership, leading people, personal leadership, and unleashing innovation and creativity. Implied qualities or skills underlying the key areas are those of making connections with others, commu-nicating well (skills of listening and articulation), mediating conflicts, and moti-vating others.

Models of Leadership Useful for Nursing
Empowerment

In the past, the nursing profession and its members have sometimes been, or have seen themselves as being, disempowered for a variety of reasons, including that nursing is a predominantly female profession (Manojlovich, 2007; Mathe-son & Bobay, 2007). Thus, use of an empowerment model of leadership make sense when educating nurses to be leaders. The theoretical basis for the empower-ment model is found in Paulo Freire's critical pedagogy of the oppressed. Freire's contention is that the oppressed must be made aware of their position and the reasons they are oppressed in order to be able to transcend the oppression. The oppressed must be willing to rethink their way of life and to examine their own

role in oppression if true liberation is to occur. This insight allows the oppressed to regain a sense of dignity and become empowered to act (Freire, 1970). Freire was interested in liberating oppressed members of a society to enhance their situation. The nursing profession has two related tasks in regard to empowerment: (1) it must facilitate the empowerment of its members (2) so that they can provide needed and promised (via codes of ethics) services. A nursing study (MacPhee et al., 2011) from Canada describes a nursing leadership intervention with a theoretical empowerment framework. This framework was chosen because, according to the author's research, structural and psychological empowerment resulted in safer work environments. This model was effective in developing nurse leaders by demonstrating how to remove organizational (structural) barriers and instill confidence (psychological) that the nurses had control and influence over their work environments. Empowered nurses can empower others. The outcome of the study was that nurse leaders reported "increased self-confidence with respect to carrying out their roles and responsibilities, positive changes in their leadership styles, and increased recognition of staff for positive stylistic changes" (MacPhee et al., 2011, p. 159). Another study on leadership from Iran (Beiranvand et al., 2021), demonstrates that ethical and authentic leadership empowers nurses to "feel they are in control of their working conditions and can better demonstrate their abilities and capabilities. Empowered nurses have competence, effectiveness, autonomy, find their job to be meaningful and think well about the nature of change and its effects" (p.1081).

Emancipatory

Emancipatory leadership is another model of leadership utilized in nursing. Emancipatory leadership involves integrated knowing being brought to bear on an environment to transform that environment. This model of leadership draws on Carper's ways of knowing and extends them to include sociopolitical knowledge as described by White (1995). In Barbara Carper's (1978) extensive review of the nursing literature, she identified four interrelated patterns of knowing that nurses use to achieve nursing purposes: empirics (the science of nursing knowledge of facts and evidence), esthetics (the art of nursing), ethics (what are good actions), and personal (self-knowledge). Chinn and Kramer (2008) argued that integrated knowledge permits nurses (as well as others) to free themselves from situations that limit ethical actions (see **Figure 5-1**).

Jackson and colleagues (2009) proposed that each of the areas of knowing could also be considered knowledge required for nursing leadership. Empirical knowing facilitates appropriate and comprehensive data collection, analysis, and evaluation. Esthetic knowing can be considered the art of leadership and includes empathic understanding of others and what might motivate them. Personal knowing is essential for ethical leadership. It is the ability to know one's self and be authentic; it is the cultivation of reflectiveness to listen and evaluate one's presence as a leader. Ethical knowing supports the core values of nursing and the conduct that supports those values. The leader is responsible for the moral environment in which nursing is practiced. This includes respect for patients and colleagues. Arries (2009) found that student nurses judged their interactions with other nurses as unjust in terms of fairness and quality of the interpersonal treatment in comparison to another person or standard. Ethical leadership requires intervention when unethical
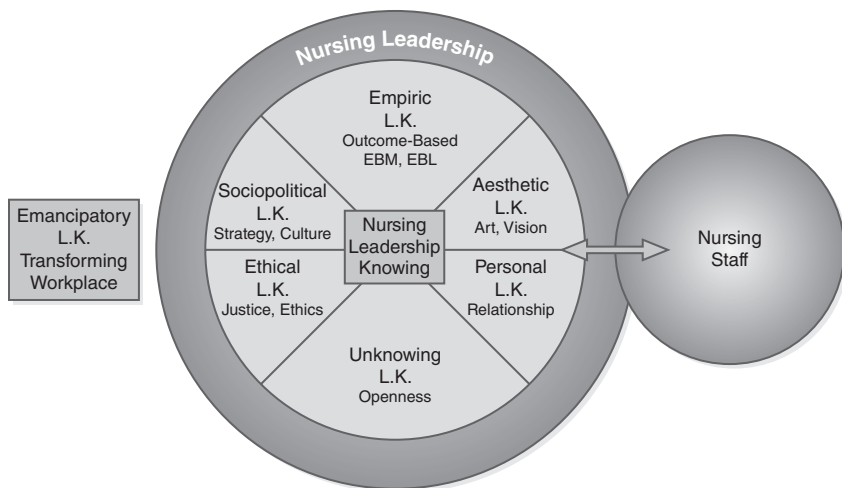
Figure 5-1 Nursing Leadership Knowing (N.L.K.) Model.

behaviors occur in the workplace. Leadership is needed for the promotion of justice, fairness, and respect for persons in the workplace and other environments in which nursing is influential.

Nursing leaders, however, are also frequently required to intervene beyond their immediate area of concern or comfort. Their contributions may be needed to make an impact on an institutional or political system where laws and healthcare justifications are made. Effective nurse leaders are knowledgeable about rules, regulations, and policies governing nursing practice, and they collaborate with others to modify them as needed. This is sociopolitical knowing. There are times when the leader does not know the answer or the direction in which to move, and acknowledgment of knowledge limits is a characteristic of the good leader. These integrated ways of knowing are possessed by effective nursing leaders and used to transform the workplace. Transformation of problem practice environments and healthcare policies requires emancipatory leadership.

Levels of Leadership

Gallagher and Tschudin (2010)—the current and former editors of the international *Nursing Ethics* journal, respectively—delineate levels of nursing's ethical leadership into micro, meso, and macro levels as below:

- At the micro level leadership involves mentoring individuals and groups at the point of care.
- At the meso level leadership occurs when nurses engage themselves in institutional committees or policies and policy development.
- At the macro level nurses tackle societal issues at the root cause of more local healthcare injustices. (Gallagher & Tschudin, 2010)

How leadership plays out at each of these levels is exemplified by real-life cases shortly. Gallagher and Tschudin (2010) emphasize the importance of knowledge of self and one's limits in effective and ethical leadership. They also highlight the reality that nurses who understand their professional responsibilities and, when necessary, assume a leadership role may sometimes opt to "follow" and support another whom they wisely recognize as better able to achieve a mutually shared purpose. Thus, leaders are sometimes followers. "Life is a constant stream of responses in conversations and to events, and how we respond to people with whom we talk, or to items of personal or media-generated news, depends largely on values that have been acquired through upbringing, culture, training, or deliberate choice. These are not static aspirations, however, and to remain ethically alive, change is necessary in order to make the fitting response in a given situation" (Gallagher & Tschudin, 2010, p. 225).

Facilitators of and Barriers to Ethical Leadership in Nursing Practice

Barriers to ethical leadership are environments that do not support nursing's goals for the good of the patient. In those environments, there are frequently no leaders who are role models for addressing the issues or barriers to good care. Nurses in these environments do not feel as though they have the ability to control their own practice or workplace. When leaders arise from these environments, it is from their own intrinsic motivation that they act and make a difference. However, nurses and even APNs may feel inadequately prepared educationally to take on a leadership role (Curtis et al., 2011).

Facilitators of ethical leadership in nursing practice are the same as those that support ethical nursing practice or environments that have the patient's, group's, or perhaps society's good as the motivator of every action. These include supportive unit or clinic structures, strong collegial and collaborative relationships, adequate preparation, and strong mentors. Other facilitators mentioned previously include leadership development academies or educational opportunities for nurse leadership. Contemporarily, there are many examples of all levels of nursing leadership, although the public visibility of such leaders may not always be as high as deserved. Nevertheless, the difference made in peoples' lives is real and often profound.

Cognitive Processes Underlying Nursing Leadership

Ethical leadership for nurses in advanced practice roles means taking action to meet nursing goals for patients, patient groups, and society and engaging and motivating necessary others in the interest of a successful outcome. The leadership process in turn can be described in terms of Rest's cognitive processes. Rest (1982) derived a model of the cognitive processes needed for ethical action—as described or exhibited by the individuals studied—from research literature. Rest is clear that this process is not a guarantee of ethically correct action, but rather is a description of what happens in the brain of a person who is motivated to do the right thing. The processes are as follows: first, a problem that has ethical aspects is perceived and interpreted; second, pertinent knowledge and analytic skills are mobilized to determine

what possible appropriate courses of action exist; third, actions are planned and initiated; and finally, the person perseveres even in the face of adversity to achieve desired goals.

Historical and Contemporary Nursing Leaders

Each nursing leader listed in this section exhibited the qualities that are needed for ethical leadership. However, their environments were such that these early leaders sometimes had to be more autocratic than egalitarian in their leadership actions. All perceived a problem that interfered with human well-being—an ethical problem—and determined that the problem had to be addressed. They used knowledge, skills, and decision-making processes to determine what possible courses of action were appropriate. They carefully planned their actions, enlisting the assistance of powerful and/or influential others as needed. Finally, they persevered until nursing goals were actualized.

Leadership at the Macro or Health-Policy Level

Florence Nightingale saw that soldiers from the Crimean War were dying of typhus and cholera in far greater numbers than soldiers who were dying of wounds. She understood that these were needless deaths and also what was needed to lessen the death toll. But she met resistance from the military doctors and leaders. She used data, influence, and persuasion in order to be allowed to change the situation. She and her nurses traveled to the front lines, where they activated sanitation measures that were successful in reducing the death rate by two-thirds (Lee et al., 2013).

Mary Breckenridge was born to a wealthy Kentucky family. She was aware of the terrible deprivations suffered by the poor people in the Appalachian states, especially the high infant mortality rate. Having suffered many losses herself and having been exposed to the work of the British nurse-midwives in France during World War I, she was determined to acquire the education she needed to change the situation. Using a model of care she had witnessed during her nursing education in Scotland and funding it out of her own money-raising efforts, she set up a decentralized system of clinics staffed by nurse-midwives from the United Kingdom who went out to the homes of patients to give primary health and midwifery care. Eventually, as the U.K. nurses left for home, Breckenridge set up a school in Kentucky to educate the first U.S. nurse-midwives (American Society of Registered Nurses, 2007).

Other examples of nurse leaders in the United States can be found at the American Academy of Nursing website, *Raise the Voice: Edge Runners.* All of these APN nurses "are the practical innovators who have led the way in bringing new thinking and new methods to a wide range of healthcare challenges. Edge Runners have developed care models and interventions that demonstrate significant, sustained clinical and financial outcomes. Many of the stories underscore the courage and fighting spirit of nurse leaders who have persevered despite institutional inertia or resistance" (American Academy of Nursing, n.d.). Additionally, scattered throughout the IOM's report, *The Future of Nursing: Leading Change, Advancing Health*, are more examples of leadership, almost exclusively demonstrated by APNs (IOM, 2011).

Leadership at the Meso Level: Contributions to Organization Discussion and Policy

Two APNs with whom the second author of the chapter (Grace) has collaborated on ethics-related projects—Ellen Robinson, Clinical Nurse Specialist in Ethics at Massachusetts General Hospital (MGH) and Martha Jurchak, former Executive Director of the Ethics Service at Brigham and Women's Hospital (BWH) in Boston, Massachusetts—are exemplars of transformational leadership at the institutional level. In the necessarily interdisciplinary settings of their institutions, they provide ethics leadership that is aimed at including consideration of all relevant perspectives. In addition, both have been instrumental in mentoring other staff and APNs to institute interdisciplinary ethics rounds and ethics on their units in the interests of good care. Finally, Robinson, Jurchak, Grace, and MGH Chaplain Angelika Zollfrank, with funding from a U.S. Government Health Resources and Services grant, were able to develop and put into practice a model of ethics education that enhances the confidence of point-of-care nurses and APNs in their ethical decision making and advocacy. This endeavor is called the Clinical Ethics Residency for Nurses (CERN) (Grace et al., 2014; Robinson et al., 2014).

On a visit to Switzerland in 2013, Grace met several APNs who had also exhibited leadership at the meso level. Hansruedi Stoll was a master's prepared oncology nurse and educator at the Universitätsspital Basel. His interest in informed consent issues led him to develop an outpatient program to help people interpret what they want from their lives. In the course of their discussion Stoll noted "what a person wants is a core question to explore in discussing an advanced directive with them. This includes exploring their values, plans, and what makes life worth living for them. This cannot be answered by a certain milligram of an anticancer drug." Stoll also models this philosophy and approach with colleagues and students. Monica Fliedner is a master's prepared oncology/palliative care nurse at the University Hospital in Bern, Switzerland. Along with colleagues, she recognized the need for a dedicated palliative care unit in her hospital and was instrumental in proposing and collaboratively developing an inpatient palliative care unit in her institution where members of different disciplines work together to plan and provide the best care possible for patients.

Leadership at the Micro Level: APNs as Role Models in Their Work with Individuals and Teams

Ursi Barandun Schäfer is a clinical nurse specialist for the surgical intensive care unit at the Universitätsspital Basel. One of her many leadership activities involves using a model of ethical decision making developed by an interdisciplinary team, of which she was a member. This model guides unit nurses in their early identification of emerging ethical problems, analysis of the issues, and ways of collaboratively addressing the problem. In this sense, it serves as a preventive ethics strategy. Additionally, the authors of this chapter believe that APN educators have an obligation to mentor their students in leadership roles. Case analyses, group discussions, and role playing can all help to develop APN leadership characteristics. Such activities can be considered leadership at the micro level.

Special Conditions Requiring Leadership: Dual Loyalties

There is recognition that military healthcare providers, regardless of country and like their nonmilitary colleagues, continue to be confronted with situations that cause moral distress. It is also recognized that situations of moral distress can be compounded by the problem that military healthcare providers suffer from the problem of dual loyalties (Williams, 2009). The problem of dual loyalty is discussed in detail in Chapter 12. Nurse leaders/military officers are called upon to demonstrate loyalty to both the military and their patients. There are good reasons, in times of war or conflict, why there are expectations of obedience based on rank within the armed forces. In general, this is thought to contribute to efficiency and effectiveness. However, the same expectations can cause problems for those who are also expected to heed their profession's code of ethics. An example of how the problem of dual loyalty can present a dilemma for the nurse follows. Implications for nurse leadership are discussed in terms of preventive ethics and the need to address policies and provide educational support for healthcare personnel in the military related to such problems.

CASE STUDY 5-1

Dual Responsibilities and Conflicting Duties: Obey Orders or Reduce Harms?

A military pilot was transported to the hospital for immediate surgical stabilization after crashing his fighter jet into the ocean. According to immediate reports, the pilot "lost the bubble," which is military flying slang referring to losing one's equilibrium or control of the aircraft and ejecting from the aircraft without following proper procedure. The pilot not following the proper procedure resulted in a death and debilitating injuries to several others.

Surgery and subsequent hospitalization took place in a military hospital. The military physician caring for the pilot had written medical orders that he was not to be disturbed, questioned, or interrogated. Physician orders stated that vital signs were to be obtained and normal nursing duties were to be carried out, but no other communication or visitors were allowed. Within 24 hours of the pilot being admitted to the orthopedic hospital wing, an entourage of high-ranking military officers showed up at the nurses' station very early on a Sunday morning. Several enlisted medical personnel and one entry level-ranking officer staffed this hospital wing. Upon reaching the nurses' station, the general from the pilot's home base demanded to see him. Although the low-ranking military nurse explained to the general that he had physician's orders that the patient was not to be disturbed, the general became increasingly impatient and at times belligerent. Military chain of command is rank determined: regardless of the branch of service, the higher-ranking officer prevails with orders that are to be followed. During this encounter, the nurse was threatened with loss of rank, punishment under the Uniform Code of Military Justice and potential court martial for refusing the commands of not only a higher-ranking officer, but of a commanding general. The nurse was concerned for his patient's optimal recovery. The pilot was still heavily sedated for pain and had expressed sadness and anxiety about what had happened. Moreover, his assessment was supported by the physician's order.

Case Discussion

Fortunately, in this situation, the hospital command (leadership) had anticipated such a visit and provided the staff with avenues of action. However, the dilemma is evident: nurses serving in the military walk a fine line, balancing between ensuring that the military mission is met while continuing to provide appropriate health care for patients regardless of whether they are military personnel or detainees. Leaders, military and otherwise, have obligations to anticipate tensions related to dual loyalty and put protocols into place that provide guidance for, and prevent retaliation against, the healthcare providers who are striving to provide ethical patient care.

Several recommendations have been made to safeguard the ethical practices of military healthcare personnel. In March 2015, the Defense Health Board's Medical Ethics Subcommittee, which advises the Secretary of Defense on health policy, compiled a 104-page report entitled *Ethical Guidelines and Practice for U.S. Military Medical Professionals.* These recommendations suggested the following:

- Create an office within the Department of Defense dedicated to ethics, leadership, policy, and oversight.
- Establish specific education and training programs in the area of ethics.
- Form policies recognizing that the military health professionals' first ethical obligation is to the patient.
- Develop mechanisms that allow health professionals to be excused from participating in medical procedures that violate their professional code of ethics.

Should these recommendations be taken seriously, they will provide a platform and anchor upon which nurse leaders can draw to reinforce nurse moral agency even under extremely difficult circumstances, of which the dual-loyalty problem may be seen as an extreme example.

Summary

The nursing profession should encourage all nurses, particularly APNs, to be leaders. The content of APN education varies internationally, but the same critical skills are needed for leadership in health policy and public health, in addition to the clinical skills for direct care, in order to meet nursing's goals. Where any of these foci are not included in curricula, nurse educators need to lead the way in advocating for their inclusion. APN graduates are encouraged to seek additional opportunities for leadership development commensurate with their practice setting and associated leadership needs. As all leadership in nursing must be aimed at improving individual and societal health, an ethical nurse leader is one who takes this charge seriously, identifies deficits in the environment, and works for change that serves the needs of the population, whether it is an individual patient, group, society, or global concern. Nurses have unique perspectives on health care and the care needed for health. They should continue to involve themselves in contemporary healthcare debates and equip themselves to provide leadership for change.

Discussion Questions

1. Who are the nurse leaders in your country or state at the macro level? What are their characteristics? How did they achieve change?

2. Who are the effective leaders in your area of practice at the meso and micro levels? What are their characteristics? How did they achieve change?
3. What are the areas of knowledge needed contemporarily to provide leadership in the clinic environment or at the bedside?
4. Upon reflection, what do you feel you need to become a more confident, empowered leader? What skills/education is needed? How will you access those opportunities?
5. Thinking about your current context, what is one concern that has to be addressed? Suggest several appropriate plans of action that may be instituted. Describe your motivation for the action and how you will persevere through adversity.

Acknowledgment

References

Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational levels of hospital nurses and surgical patient mortality. *Journal of the American Medical Association, 290*(12), 1617–1623. https://doi.org/10.1001/jama.290.12.1617

American Academy of Nursing. (n.d.). *Raise the voice: Edge runners*. https://www.aannet.org/american academyofnursing/initiatives/raisethevoice

American Association of Colleges of Nursing. (2004). *AACN position statement on the practice doctorate in nursing.* https://www.aacnnursing.org/News-Information/Position-Statements-White-Papers/Practice-Doctorate

American Association of Colleges of Nursing. (2006). *The essentials of doctoral education for advanced nursing practice*. https://www.aacnnursing.org/Portals/42/Publications/DNPEssentials.pdf

American Association of Colleges of Nursing. (2011). *The essentials of master's education in nursing*. https://www.aacnnursing.org/Portals/42/Publications/MastersEssentials11.pdf

American Association of Colleges of Nursing. (2020a). *Fact sheet: Doctor of Nursing Practice*. https://www.aacnnursing.org/News-Information/Fact-Sheets/DNP-Fact-Sheet

American Association of Colleges of Nursing. (2020b). *Nursing faculty shortage fact sheet*. https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Shortage

American Nurses Association. (2013, March/April). Building a pipeline of nurse leaders. *American Nurse,* 4.

American Society of Registered Nurses. (2007, November 1). *The chronicle of nursing: Mary Breckenridge*. http://www.asrn.org/journal-chronicle-nursing/206-mary-breckenridge.html

Arries, E. J. (2009). Interactional justice in student-staff nurse encounters. *Nursing Ethics, 16*(2), 147–160. https://doi.org/10.1177/0969733008100075

Beiranvand, M. S., Beiranvand, S., Beiranvand, S., & Mohammadipour, F. (2021). Explaining the effect of authentic and ethical leadership on psychological empowerment of nurses. *Journal of Nursing Management*, *29*(5), 1081–1090. https://doi.org/10.1111/jonm.13246

Bellini, S., McCauley, P., & Cusson, R. M. (2012). The doctor of nursing practice graduate as faculty member. *Nursing Clinics of North America, 47*(4), 547–556. https://doi.org/10.1016/j.cnur.2012.07.004

Benner, P., Sutphen, M., Leonard, V., & Day, L. (2009). *Educating nurses: A call for radical transformation* (Carnegie Foundation for the Advancement of Teaching). Jossey-Bass.

Burns, J. M. (1978). *Leadership*. Harper & Row.

Canadian Nurses Association. (2019). Advanced Practice Nursing: A Pan Canadian Framework. https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Advanced_Practice_Nursing_framework_EN.pdf

Carper, B. (1978). Fundamental patterns of knowing in nursing. *Advances in Nursing Science, 1*(1), 13–23. https://doi.org/10.1097/00012272-197810000-00004

Chemers, M. M. (2001). The psychology of leadership. In N. J. Smelser & P. B. Baltes (Eds.), *International encyclopedia of the social and behavioral sciences* (pp. 8580–8583). Elsevier.

Chinn, P. L., & Kramer, M. K. (2008). *Integrated knowledge development in nursing* (7th ed.). Elsevier-Mosby.

Curtis, E. A., de Vries, J., & Sheerin, F. K. (2011). Developing leadership in nursing: Exploring core factors. *British Journal of Nursing, 20*(5), 306–309. https://doi.org/10.12968/bjon.2011.20.5.306

Defense Health Board. (2015). *Ethical guidelines and practices for U.S. military medical professionals*. www.health.mil/reference-Center/Reports/2015/03/03/Ethical-Guidelines-and-Practices-for-US-Military-Medical-Professionals

Dyess, S. M., Sherman, R. O., Pratt, B. A., & Chiang-Hanisko, L. (2016). Growing nurse leaders: Their perspectives on nursing leadership and today's practice environment. *OJIN: Online Journal of Issues in Nursing, 21*(1). https://doi.org/10.3912/OJIN.Vol21No1PPT04

Edmonson, C. (2010). Moral courage and the nurse leader. *OJIN: Online Journal of Issues in Nursing, 15*(3), manuscript 5. https://doi.org/10.3912/OJIN.Vol15No03Man05

Freire, P. (1970). *Pedagogy of the oppressed*. Herder and Herder.

Gallagher, A., & Tschudin, V. (2010). Educating for ethical leadership. *Nurse Education Today, 30*(3), 224–227. https://doi.org/10.1016/j.nedt.2009.11.003

Grace, P. J. (2001). Professional advocacy: Widening the scope of accountability. *Nursing Philosophy, 2*(2), 151–162. https://doi.org/10.1046/j.1466-769X.2001.00048.x

Grace, P. J., Robinson, E., Jurchak, M., Zollfrank, A., & Lee, S. (2014). The Clinical Ethics Residency for Nurses (CERN): An educational model for ethics leadership at the bedside. *Journal of Nursing Administration, 44*(12), 640–646. https://doi.org/10.1097/NNA.0000000000000141

Grace, P. J., Willis, D. G., & Jurchak, M. (2007). Good patient care: Egalitarian inter-professional collaboration as a moral imperative. *American Society of Bioethics and Humanities Exchange, 10*(1), 8–9.

Grimm, J. W. (2010). Effective leadership: Making the difference. *Journal of Emergency Nursing, 36*(1), 74–77. https://doi.org/10.1016/j.jen.2008.07.012

Howell, J. M., & Avolio, B. J. (1993). Transformational leadership, transactional leadership, locus of control, and support for innovation: Key predictors of consolidated business-unit performance. *Journal of Applied Psychology, 78*(6), 891–902. https://doi.org/10.1037/0021-9010.78.6.891

Institute of Medicine. (2011). *The future of nursing: Leading change, advancing health*. National Academies Press. https://www.nap.edu/read/12956/chapter/1

International Council of Nurses. (2012). *The ICN code of ethics for nurses*. https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20eng.pdf

International Council of Nurses. (2020). *Guidelines on advanced practice nursing*. https://www.icn.ch/system/files/documents/2020-04/ICN_APN%20Report_EN_WEB.pdf

Jackson, J., Clements, P., Averill, J., & Zimbro, K. (2009). Patterns of knowing: A theory for nursing leadership. *Nursing Economics, 27*(3), 149–159.

Judge, T. R., & Piccolo, A. F. (2004). Transformational and transactional leadership: A meta-analytic test of their relative validity. *Journal of Applied Psychology, 89*(5), 755–768. https://doi.org/10.1037/0021-9010.89.5.755

Kirkpatrick, S. A., & Locke, E. A. (1991). Leadership: Do traits really matter? *Academy of Management Executive, 5*(2), 48–60. https://doi.org/10.5465/ame.1991.4274679

Lachman, V. D. (2007). Moral courage: A virtue in need of development? *MEDSURG Nursing, 16*(2), 131–133.

Lee, G., Clark, A. M., & Thompson, D. R. (2013). Florence Nightingale: Never more relevant than today. *Journal of Advanced Nursing, 69*(2), 245–246. https://doi.org/10.1111/jan.12021

MacPhee, M., Skelton-Green, J., Bouthillette, F., & Suryaprakash, N. (2011). An empowerment framework for nursing leadership development: Supporting evidence. *Journal of Advanced Nursing, 68*(1), 159–169. https://doi.org/10.1111/j.1365-2648.2011.05746.x

Magyary, D., Whitney, J. D., & Brown, M. A. (2006). Advancing practice inquiry: Research foundations of the practice doctorate in nursing. *Nursing Outlook, 54*(3), 139–151. https://doi.org/10.1016/j.outlook.2006.03.004

Manojlovich, M. (2007). Power and empowerment in nursing: Looking backward to inform the future. *Online Journal of Issues in Nursing, 12*1), manuscript 1. https://doi.org/10.3912/OJIN .Vol12No01Man01

http://ojin.nursingworld.org/mainmenucategories/anamarketplace/anaperiodicals/ojin/tableof contents/volume122007/no1jan07/lookingbackwardtoinformthefuture.asp

Matheson, L. K., & Bobay, K. (2007). Validation of oppressed group behaviors in nursing. *Journal of Professional Nursing, 23*(4), 226–234. https://doi.org/10.1016/j.profnurs.2007.01.007

Miller, J. (2008). The doctor of nursing practice: Recognizing a need or graying the line between doctors and nurses? *Medscape Journal of Medicine, 10*(11), 253. https://www.ncbi.nlm.nih .gov/pmc/articles/PMC2605113

Murphy, L. (2005). Transformational leadership: A cascading chain reaction. *Journal of Nursing Management, 13*(2), 128–136. https://doi.org/10.1111/j.1365-2934.2005.00458.x

National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. National Academies Press. https://doi.org/10 .17226/25982

Pulcini, J., Jelic, M., Gul, R., & Loke, A. Y. (2010). An international survey on advanced practice nursing education, practice, and regulation. *Journal of Nursing Scholarship, 42*(1), 31–39. https://doi.org/10.1111/j.1547-5069.2009.01322.x

Rest, J. R. (1982). A psychologist looks at the teaching of ethics. *Hastings Center Report, 12*(1), 29–36. https://doi.org/10.2307/3560621

Robinson, E., Jurchak, M., Zollfrank, A., Lee, S., Frost, D., & Grace, P. J. (2014). Enhancing moral agency: Clinical Ethics Residency for Nurses. *Hastings Center Report*, *44*(5), 12–20. https://doi .org /10.1002/hast.353

Rodriguez, E. S. (2016). Considerations for the Doctor of Nursing Practice degree. *Oncology Nursing Forum, 43*(1), 26–29. https://doi.org/10.1188/16.ONF.26-29

Sherman, R. O. (2013). Too young to be a nurse leader? *American Nurse Today, 8*(1), 34–37.

Shirey, M. (2007). Competencies and tips for effective leadership: From novice to expert. *Journal of Nursing Administration, 37*(4), 167–170. https://doi.org/10.1097/01.NNA.0000266842 .54308.38

Sullivan, E. J., & Garland, G. (2010). *Practical leadership and management in nursing*. Pearson Education.

United States Bureau of Labor Statistics. (2020). *Labor force statistics from the current population survey*. https://www.bls.gov/cps/cpsaat11.htm

Weihrich, H., & Koontz, H. (2005). *Management: A global perspective* (11th ed.). McGraw-Hill.

White, J. (1995). Patterns of knowing: Review, critique, and update. *Advances in Nursing Science, 17*(4), 73–86. https://doi.org/10.1097/00012272-199506000-00007

Williams, J. R. (2009). Dual loyalties: How to resolve ethical conflict. *South African Journal of Bioethics and Law, 2*(1), 8–11.

Willis, D. B., Grace, P. J., & Roy, C. (2008). A central unifying focus for the discipline: Facilitating humanization, meaning, choice, quality of life and healing in living and dying. *Advances in Nursing Science, 31*(1), E28–E40. https://doi.org/10.1097/01.ANS.0000311534.04059.d9

Zaccagnini, M. E., & White, K. W. (2011). *The doctor of nursing practice essentials: A new model for advanced practice nursing*. Jones & Bartlett Learning.