- [Joanne] Good morning.
- [Audience] Good morning.

- I am so pleased to be here. I have to give kudos to the Planning Committee. This is really a most innovative conference that just so reflects nursing today. The talk we'll hear later about trust. As nurses, we're all emotionally intelligent. I'm going to talk a little bit about a particular source of power that we have. It's a talk I really enjoyed putting together, and I've never given, although maybe you, like me, the night before you give a talk, you dream about it all night. Actually, I gave it about six times during the night. So I think it might be kind of polished. I don't know. We'll wait and see.
- [audience laughter]

On this seventh try, it's good to be with you this morning to talk about something that I've been involved in for more than 45 years, and that's being a nurse. I tell my students I'd choose it tomorrow. It's the very best opportunity for anybody, man or woman. So to reflect on some issues and some opportunities is very exciting for me today.

Nurses are everywhere, and we do a miraculous array of things. We're in all countries. We're in all points of life. We're in all settings, the home. We are helpful to each other in these settings. But we're not in Kansas anymore. Things are very different than they were back in the day or back in our days.

So what I'd like to do this morning is talk a little bit about the context of health care today. As I often say, this is not God's truth. It's just Joanne's thoughts. We'll have some opportunity to talk a little bit about, "Well, I don't really quite see it that way, Joanne." That would be great. Then we'll have some dialogue.

To look at what the nursing lens is, and this is something that has occurred to me maybe over the last 10 years about a source of power that I think we take for granted. To then look at three essential skills, if we're talking about excellence. This idea of the purpose of this conference really stimulated me to think about, "Well, what is excellence?" I'll share with you three things that I think are fundamental.
Then I will talk about, not the text, but the concept of person and family-centered care and how nurses, because I think this is one of the largest movements in health care in, I don't know, 100 years is the push for individuals and their families to be actively involved in all aspects of health care. Who better than nurses to really capitalize on that? We have such a close relationship. The public trusts us. If we can step up and take advantage of that, we will be in the driver's seat.

So I would ask you: What do these have in common? They offer health care. There's a lot of people. There are a lot of things going on, but they all offer health care. Really? Yes. Down in Owatonna, outside of Rochester, Mayo Client Affiliated, they have flu shots available here. A number of us were laughing a while back about, "Sure, what do you do? Drive through, stick your arm out, and get a flu shot?" Well, just about.

The challenges of regulating care everywhere it's offered is increasingly challenging. Also providing and educating the students about how to provide care in a gas station, what do you have to think about? What's the equipment?

But again, nurses are everywhere -- schools, clinics, nursing homes, in homes, on the street. I say to nursing students -- I taught for 10 years leadership to the nursing students -- "How do you give home care to the homeless? What are the principles that apply?"

[[0:03:59]]

And then on the right, I say to the students, "Nursing care is everywhere. Can you think of a place where nurses aren't practicing?" One of the students, kind of perky, said, "Yeah, how about in a bar?" I said, "Really? I could think of ways in which nursing care might be practiced in a bar or a tavern." I challenged them. I said, "Can you think of anything?"

A few of them thought. I would ask you. What aspects of nursing care might be provided in a bar or a tavern? - [Audience] Mental health. - Mental health. [audience laughter] Yeah, seriously. Addiction. - [Audience] STD counseling. - STD counseling, and that is very active on the East Coast. Somebody said, "Well, if they fell off the bar stool, then you've have some kind of orthopedic or some kind of a neuro thing," but the point being nursing care.

On an airplane, how many of you have been asked to help in an emergency? Yeah. One flight from Europe to the United States, we had two emergencies. Were there supplies? Well, the IVs had run out with the first person, so thank goodness the second person didn't need intravenous fluid. The point being, nurses are called upon to practice pretty much everywhere.

This has become commonplace. We're using new tools. How many of you know a plate as a tool for long distance health care? It's called a plate that knows what's on it. This is a tomato that's on it, but that's the only picture of a plate I could find. A plate that knows what's on it, anybody familiar with that concept? Again, a tool that we use.

Our colleague, Patty Brennan from the University of Wisconsin who has been a department chair in the College of Engineering, doctoral-prepared nurse, department chair in the College of Engineering at Wisconsin, and her
colleagues designed this. So what it is, is a plate that you give to somebody. It doesn't quite look like this because it's marked into quadrants. The upper quadrant is for pasta. The lower quadrant is for fruits, greens, and protein.

If you go home, when you go home and you load up your plate for your meal, if you have the right proportion according to your prescription, a rim glows green. If you do not and perhaps a little too much of the lower left pasta or a little too much of something else, the rim glows red. So the idea of what tools we can use and how we can provide such care from a distance is so convenient and yet so challenging for us to develop practice standards, for us to educate the students, and for all of you to help us move health care forward, but in a very different kind of a world.

Unfortunately, with all of these tools and all of these settings, care is not becoming safer. I think you probably have heard the more recent, from last year, statistics that 98,000 people are not dying annually from medical error. 400,000 are dying annually from medical error. Is that just because we're reporting better? I think not. So hundreds of thousands of people are dying from medical error. So we have got to get on top of this in so many different ways.

What we see nationally, again the context within which we're all trying to do our various roles or many roles, is improving the experience of care, the health, and then reducing costs.

With the Affordable Care Act, again, better care, affordable care, healthy people in communities. There are new directions in health care. Again, I never would have thought of this in my lifetime, that we would see some of the changes that are so supportive of what nurses believe have to be happening, so that there's affordable health care for most Americans, preventive care, mental health being better covered, data to make decisions, reduced costs, patient engagement.

And that there are many forces that are pushing society, not just because nurses are good people and they're trying to show that we like you, you men and women, but very pragmatic, practical forces from the American Hospital Association, the Joint Commission, and all manner, Congress even, that nurses will be full partners, that the scope of practice barriers will be eliminated.

I am so proud that finally in Minnesota, a state that we thought would never see the light of day, has made tremendous accomplishments and now APRNs have full scope. Expert teams of health care professionals, in the past we worked toward bringing the experts together and creating a team. Now this whole concept of an expert team, which is very exciting because it doesn't mean just a whole gaggle of people coming together and bringing their expertise and throwing it on the table. The creation of expert teams is very different than teams of experts. I would say most academic health centers are still targeting to bring together the various professions and smush them into some form of a team, when really we should be creating expert teams, which is a very interdependent, very different kind of an animal. Then care will not just be patient centered but person driven.

I am so optimistic because I really believe we are in the driver's seat. When you think about what nurses know, our background, we are so crafty. We can come up with supplies and resources and maybe a nurse for an evening
shift or something when nobody can bring forward the resources that are necessary. We can see the big picture. We know that it's not just the surgery on the foot, but is the person able to walk?

I remember when I started my career in a CV surgery ICU. The surgeons would come down and say, "Oh my gosh, that was a fabulous surgery. We were on and off the pump in about 27 minutes. There was no bleeding. Nice anastomosis." They'd be sitting around the ICU desk talking about it, high fiving. I would go in the patient's room. Days later, weeks later, the patient still had angina.

[[0:10:00]]

It was not a good surgery from the patient's standpoint, but technically it was an excellent surgery. Both are important. It's not like, who cares about the technical, but it's we have to address both. This idea, nurses understand that. Trust by the public, committed to the endpoint, which is better health and not just getting out of the hospital.

And then also, I think we can relate effectively to such a wide range of people. When I interviewed to get on the board for AARP, I was being interviewed by a group of 10 people. It was very clear that one of the people absolutely disliked me intensely. I had just met the guy. He's sitting there. You think, "How would you know that?"

I'll show you how I knew it. Every nurse in the room would know this too. Literally, he was looking at me like that. I thought, "That's dislike. I think that's dislike. But what's it due to?" He asked me a question. I had no idea what to answer. He was a Vice President for Sachs. I said, "Well, you know, that's a good question." Trying to, "What am I going to say here?"

He said, "I don't care if it was a good question. I want a good answer." I was like, oh, angry, hostile person. But what happened, I realized what went in my head immediately was, "Angry, hostile patient who doesn't like diagnosis. There's something going on the environment." It wasn't me, but I immediately thought and my nursing sort of history brought it forward. It just snapped in my mind.

I didn't snap back at him. I talked with him and finally found out a whole bunch of issues, unrelated. He had misunderstood my CV and a bunch of things. Well, he became my mentor and really eventually helped me then move into the chair role. From just absolute dislike to I learned his story, which is again a very nursing thing that all of us do.

[[0:11:57]]

So what occurred to me over the years in my different experiences was there is a specific way that we nurses think. I don't mean that in a weird way or anything. Yeah, we are kind of strange. We can talk about things at dinner that nobody else would want to hear about at all in their life. The slide yesterday about "maybe you don't want to see this," that was a little much from that restaurant with the worker, yeah, even a nurse, blah.

We can really understand things at a very different level. What occurred to me is -- I did, maybe you have not -- but I really have taken this for granted, what I have come to call the nursing lens. What it is, is this combination of all these things I've just been commenting on about what it is that makes us special, and really connect with the public, and really able to do innovative, creative things that nobody else would think of.
It's not that we're smarter -- I'm not saying that -- or better than physicians or pharmacists or social workers. They have their social work lens. I don't know what that is because I have not been a social worker for 45 years, but I've been a nurse. I think, and again this is not a function of somebody passing the NCLEX or their boards back in the day. You don't get that from sitting for an exam.

I noticed somebody looking. I apologize. I always have to submit something because I'm asked to submit, and then I change as I'm thinking about what I want to way. A lot of my slides are in your packet, but Colleen assured me that they will all be posted. If you want to see all these slides in their sequence that I'm going through now, I did reorganize because it made more sense to me and I hope to you. Anyway, I wanted to apologize for that.

What occurred to me was this is very different than others and than physicians. Again, not better, just different from how physicians might look at situations. All of us are needed in health care. I really began to appreciate and look around me when I encounter this nursing lens in practice.

Here's a couple of examples of what I mean, to give you that sense. On the left is Carolyn Robinson, who's a clinical specialist at the VA in Minneapolis, and Diane Treat-Jacobson. They worked together on a program that we used to have at the Densford Center when I was at the school called the Densford Clinical Scholar. We would bring together a clinical specialist and a faculty member. They'd work together on some clinical issue of great importance to the clinical facility.

It wasn't just a researcher coming to a clinical facility saying, "I'd like to do my research here. Do you want to partner with me?" They really worked together. Diane's issue that Carolyn had seen in the clinic was that patients with peripheral vascular disease -- and Diane had been president of the society at one point -- really had a terrible time with exercise because their legs hurt so bad that they couldn't exercise, which then caused their legs to deteriorate further. They had this terribly bad cycle that just eventually would result in amputation.

So Diane worked with some surgeons who were talking, obviously very often about, "You need to amputate here. You need to amputate." Diane was like, "No, I think there's a better way. I don't think we should be spending our time on trying to find a better way to amputate. I think we should do whatever we can do to try to salvage the limb and not just have a limb that's not very functional."

So Diane remembered a study she had heard about in, I think, Sweden or someplace in Scandinavia. What she did was design a study to use upper body ergometry to see if it improved lower body functioning, and it did. It served as a seed grant for a huge NIH grant. It has now been applied to all number of applications where, for some reason, people can't at the beginning really use their legs. They can increase their capacity if they use upper body exercise.

Now I think that's an example of the nursing lens, that somebody didn't want to just do the current surgery better, but let's see if we could do something that's more patient focused so that they would have a quality of life.
Another example is a clinical specialist -- actually, I think she also was at the VA -- who was seeing a patient with a physician. The physician gave exquisite home instructions about, "Here's the drug and here's what it does. If you gain more than three pounds a week or something, I'd like you to come in and see us," and on and on. "Any questions?" "No. Things are fine."

The physician left the room. The nurse sat there for a minute and she said, "You don't have a home, do you?" He was homeless. She didn't say that in a pejorative way, but a recognition that there is no scale that he's going to be able to . . . even if he wanted to do the right thing, there's no scale. She said to him, "What I'd like you to do is notice if your shoes start feeling too tight." She knew that would be something he could track, which could indicate that he was starting to accumulate fluid.

Again, I think an example of how a nurse personalizes according to the individual setting and comes up with, I think, kind of a crafty little example of how to meet a patient's needs, but not in a traditional way.

We have a lot of national leaders who use a nursing lens, some of whom you will know. Marilyn Tavenner and some of the decisions she's made, you know that if others had been in that office might not have gone the way they did. Mary Wakefield. Richard Carmona. Patricia Horoho.

You probably don't know the fifth woman. That's Carol Z. Garrison, who until recently was the President of the University of Alabama at Birmingham, a nurse. Then on the right is Jeannine Rivet. Now probably very few of you know Jeannine. I didn't know her until about 10 years ago.

She is probably the most powerful woman at UnitedHealth Group, which is a gazillion dollar insurance company just outside of Minneapolis. Jeannine is incredibly influential, incredibly powerful. When I first met her, when I went to the School of Nursing, she told me how she used to be a nurse. I said, "Oh, Jeannine." I couldn't believe that I said this. I was just meeting her and we were wanting her to be like a sponsor of our program at the school.

I just blurted out, "Oh, Jeannine, I think you use your nursing every single day." She looked at me. "What do you mean?" Very gracious. I never so much felt like I had hay sticking out of my mouth as being in her very corporate office and telling her she was wrong. But I just blurted it out.

I said, "How you prepare for meetings, how you read the body language, how you know how to use this kind of an approach for that person but this kind of an approach, how you organize, how you adapt, how you know what your customers really want." I gave a number of examples. She said, "Wow, I never really thought about that."

I am so proud to say that, eventually, she came back into being active in nursing. She gave the graduation address several years later at the School of Nursing and started sort of in Geraldine Ferraro style, "I'm Jeannine Rivet. I work at UnitedHealth, and I am a nurse." So she could see the power of what it is to bring your nursing lens to something that I think the people at UnitedHealth don't even know that she had a nursing background.

It's not maybe, "I used to be a nurse." It's, "I have nursing in my background." When people say, "I used to be a nurse," sometimes people just gleefully disdain their background. It's like, how foolish, because you probably use it every day.
Even in Congress, this person grew up, obviously a nurse, to become this person -- Lois Capps, Congresswoman. So the idea that the nursing lens, and again you may or may not see it that way, but it's been a very powerful motivator for me to think about, "What is it that we bring to society, and why are we given such respect and trust and admiration?" This conference made me think a little bit about it.

What is excellence? It's sort of like the old "I know it when I see it." But we probably have to get a little bit more granular than that. How do we teach it if we can't describe it or measure it, etc.? I went to the dictionary. I thought it was interesting: extremely high quality; superbness, I've not ever used that word, superbness, the Institute of Regulatory Superbness, you may want to evolve into that; excellency; first-rateness. The point being it's up here. The idea of excellence, I'm going to get back to that when we talk about health care and what is excellence or quality in health care.

What does it take to be excellent? What occurred to me that it takes is at least three fundamental things. There may be other things. First, there has to be a sense of competent practice. The Institute of Medicine has said, "All health profession students will demonstrate these competencies on the left-hand side." Not just nursing, not just if you feel like it, but every health professional school will move to demonstrate those.

In the middle column is the quality and safety education for nursing or QSEN competencies. The idea of the competencies is to prepare students to practice in contemporary reality. Then the AACN essentials. Had I space, I would have added the NLN standards as well. To show the crosswalk that there's really growing agreement among many national groups and organizations about what does it take for competent practice. We don't need to spend a lot of time on that because there's a growing consensus.

The second is that it takes leadership. This is the definition that I use. It's probably the simplest you've ever seen, but I think it's potentially powerful. The idea of working with and through others. The old day of the leader and then the little followers is over. Leadership involves skills at working with and through others to improve something.

Those of you who are in the institute, you're working with and through others and working to improve something, not just get the job done, which is also important, but that's what managers do. Leaders look at something and say, "There's a better way to do this." Diane Treat-Jacobson was a leader in terms of clinical practice.

Leadership, two comments I will make. I also say to our undergraduate nursing students, with that definition -- if that's the definition -- every nurse has to be a leader, working with and through others to improve something. This is not just about the people. All of us in this room I think would be qualified as leaders with a big "L." We have a formal title. We have a position. It's kind of clear that we're in a leadership role.

These are some people. Garrett Chan from California. An individual who died, Joyce Clifford. Dan Pesut from Minnesota now. And then Cheryl Hoying, formerly President of AONE. We are here. There are leaders with a big "L," people who would say, "Yeah, that's a leader." But these two are what we used to call "The Rachels." These are undergraduate students of mine two years ago -- Rachel Kessie and Rachel Isaacs.
We would tell the undergraduate students that you need to develop your leadership capacity because, one, you have to work with and through others. Two, you need to improve things. With a small "L," everybody has to be a leader, or you can assume a position. Again, teaching the undergraduates leadership, they'd be like, "I don't want to become a nurse leader. I don't want to become a nurse manager."

I don't necessarily care that you do either, but you do have to exert leadership skills if you're going to work with and through others to improve something. So at that level, you might not think of yourself that way, but we have to work with you this semester. That's one comment about leadership.

Then, I do think we need a certain kind of leadership today. It's not just executing the plan. But with so much dynamism and so much change going on -- and some that I just illustrated -- we can't be satisfied with just executing the current plan. We have to do that while we anticipate and change and decide what needs to be done differently next Thursday, next month, next year. That's very challenging.

In the old day, we just had to make sure here is the plan, here are the standards. Now we just have to make sure that everybody adheres to them. Well, I would say that one of your challenges is helping people adhere and be held accountable for the standards at the same time you're looking to see what maybe do we need to think about changing next year or two years down the pike. Very much more difficult.

So I think we need leaders that really surround themselves, like you're doing here, with people who think differently, who don't maybe agree with you. There's nothing more powerful -- witness my friend Chuck from AARP -- to really encounter somebody who you bitterly disagree with and sit there and listen to what they think about. There's nothing for fun than sitting together at table like, "Oh my god, I wish everybody could think like I do or like we do. Couldn't we just make sure everybody thinks this way?"

I was like, "Maybe." But isn't it more, "Why do they think that they? Maybe I'm, if not wrong, maybe I could change my thinking a bit." So it's not so much about us influencing them. It's about why do you think the way you do, and how do we come together for common action. So I believe we do need generative leaders.

Then the third thing, I believe, is a change in thinking, that leaders and, frankly, people who walk the face of the earth today, we need to think differently about a whole host of things. Nationally, this big push from the Future of Nursing report, really hoping the country will move from thinking of nurses as functional doers -- "Here we go. Yeah, that's what we're told to do, so we're going to do it -- to thoughtful strategists.

We obviously have a little work to do. If you have been exposed to that op-ed from The New York Times -- not The New York Times, the other paper in New York -- from the woman who said, "Advanced practice nurses are just dangerous. Don't go to one if you care about your health." Really? Somebody believes that? They write that in today's society? Yeah, sometimes people still believe that. Not everybody understands the thoughtful strategist part and the role that nurses play.
So we still have some work to do. But more and more organizations are saying, "We've got to get nurses on board. We've got to get them out there. We've got to get them in leadership positions." Not because they're better, but because we offer a different perspective.

I'm going to spend a little time with you this morning, because I feel so strongly about this, learning to think differently. This is, I think, complementary to what we heard yesterday. Influence is crucial. How do we influence others? How do we work with and through others to improve something is a great application of influence. And I would also say, not instead of, that we also need to challenge our own thinking and maybe influence ourselves and think differently ourselves as we work to influence others. So I think this next section, I hope, is complementary to yesterday. There's a rich both working to influence others, but also changing ourselves.

[[0:27:56]]

We're going to do three what might be counterintuitive strategies. Number one is to embrace paradox. Two is to seek ambiguity. Historically, it was to seek clarity. I want to give some suggestions about: How do we benefit from ambiguity? Don't we want things to be clear? Well, sometimes no. And then practice creativity. We're going to spend a little time on that. Then we're going to apply it to what I think is one of the major initiatives in these next couple of years.

Embrace paradox. What I mean by paradox is this. It's a statement that's seemingly contradictory or absolutely opposite, perhaps, but both sides of the coin are perhaps true. Here are some. When you start thinking about paradox, many years ago, it struck me that a lot of what I'm trying to do as a chief nurse is so paradoxical. I'll give you some examples.

Then you hear quotes. It really is a very interesting concept. One of my favorites is the one on the bottom. "To move freely, you must be deeply rooted." Isn't that an interesting juxtaposition? How can you be free and rooted? Well, I think you can.

Then we think about health care paradoxes. Again, as a chief nurse, I found myself on a daily basis, and it wasn't like Monday I improved quality, and Thursday/Friday I reduced cost, and it wasn't that on Tuesday . . . nurses know that more is not better. If somebody has ordered a dose of dig, you don't give them two because that's going to be even better than the one. So we know the tradeoff and the balance.

We also know and before it used to be illegal to advertise. We have to be both ethical and successful. We also have to, and this is sometimes hard, be competitive yet collegial depending on your area of the country.

[[0:29:59]]

This one is also very hard sometimes -- to be passionate about nursing and interprofessional. It's very easy to be passionate about nursing and trash everybody else. Nurses are the most important thing in the health care system, we deserve, and whatever. Well, we are important, but I would say we're no more but certainly no less important. How do we promote interprofessional practice and also be passionate about nursing? It's easy to do one or the other.
I've heard colleagues of mine say, "I just think you're too nursing oriented. Today, we're into interprofessional. Nobody is better than anybody else." I'm like, "Hey, you are so right there." But the nursing lens makes me different and my contributions not better than, but different from and often needed, depending on what's the context of health care.

Then this one, I would find myself driving home just gripping the steering wheel, doing this to get calm. I thought, "There's something wrong here." That is not how I should be trying to get calm, driving home with anger or agitation in my thoughts.

Then it occurred to me there are a lot of paradoxes when I moved across the street full time to the School of Nursing. Those of you who are educators will recognize this -- a lot of paradoxes in nursing education. The point with a paradox is you can't just, "I'm going to just do one half of the equation." It's that you've got to find a way to reconcile the paradox, otherwise we have polar opposites.

It's easy, and it was easy as a nursing student and a nurse, back in the day, to be concerned about quality and, "I don't care about the cost. When patient lives are at stake, cost has no place in the equation." Well, that's really naive. It is very inefficient. It's very ineffective today, and it's really not going to be sustainable. So we've got to find a way to improve the quality and reduce the cost. Pretty hard. Easy to do either one.

[[0:32:01]]

The idea of paradoxes is that we have to find ways to do both. Now I would ask you, at your table, just take a couple of minutes. What are regulatory paradoxes that you might face? Two sides of a coin that you have to address or two groups that you have to reconcile? I won't say appease, but reconcile. Just take a minute or two at your table to see if you can identify any inherent paradoxes in the regulatory environment.

We're not going to have time for a full conversation, I'm sorry. But anybody have any that you came up with at your table? Maybe you'll carry this conversation on later. Just the idea. Anybody have any that you came up with at your table?

- [Participant] In Canada, and certainly we're from British Columbia, we are essentially funded by the nurses, but as regulators we don't represent them.

- Yeah, so the funders vis-à-vis the regulator, great paradox. Both need to be considered. Back there?

- [Participant] I was talking at our table about how advocacy is a big problem. When I came to regulation, when I got to Louisiana from education and practice and administration, I was told that our reputation was terrible in the community and that we were thought of as nothing but a disciplinary agency that's out to get nurses. I thought, "Well no, that's really not all we're about." We should be about advocating for the profession so that those two percenters -- it's only the two percenters, that's what I call them now -- that come before us for disciplinary things, that we're decreasing that because we're advocating for a better profession.

- Yeah, excellent example.

- [Participant] We are there to protect the public, but we're also there for our profession.
- [Joanne] Yes. Excellent. Yes?

[[0:33:53]]

The only one I could come up with, and you all come up with, and I'm sure if you had more time there would be a whole list of what you have to face, but this whole issue of: How do you reconcile protecting the public and supporting the profession? It's easy to protect the public and nuts to the rest. It's easy to support the profession, but really in service of the public isn't supporting the profession. What are the ways you reconcile it?

The idea of paradox I just think is rampant in society today. We need to think about it and talk about it and see how we do that.

Fitzgerald would say that, "The test of a first-rate intelligence is the ability to hold two seemingly opposed ideas in mind at the same time." It doesn't mean you have to agree with both sides. You don't take a stand, but to understand how somebody could be pro-choice and pro-life, to understand how somebody could support the profession and also promote person and family-centered care.

The idea of understanding, which means we have to spend some time with people who think bitterly different from us. This is not just north and south or racial. This is like diversity of thought. The two of us could look identical and you could be so left wing or right wing, and I could be so other wing that there seems like nothing in common. How do we make progress if we don't sit down with people who are different from us? That's obviously one of the strategies.

A fabulous book by Collins and Porras, and he went on to do "Good to Great," but this idea of the tyranny of the "OR" as opposed to the genius of the "AND" which is the both "AND. They would say, they did say, and it was very powerful to me, we have to really eliminate in our thinking but also our language this all or none, right or wrong, good or bad, you or me, doctor versus nurse, doctor or nurse. No, we're all health care providers.

[[0:35:51]]

The power of language in society is more than insignificant. We have to start thinking about ways to reconcile. I don't mean be all blurry and schmoozy in the middle, but really to reconcile very different, polar opposite sometimes points of view.

How do you embrace paradox? What are the commonalities? Think of people you bitterly disagree with. What can we agree on? Good patient care is a start. A safe public is a start. Educated workforce, do you agree on that?

Frankly, in some states, I spent some time in Florida. They are bitterly opposed to national education standards. Please. I have a hard time sitting down and talking with somebody who says, "No, let the local municipality decide what the students should learn. They shouldn't learn about this or that." It's like, oh. That's one of the hard things I have living in Florida. What do we agree on?

The second thing is: Under what conditions could we try something? The example I'll give very quickly is one that I experienced when I was at the hospital at the University of Pennsylvania. The nursing staff wanted to implement open visiting hours. This is in West Philadelphia, which then was quite a dangerous neighborhood and
was difficult. Friday night, you'd have just groups and literally gangs coming into the emergency department because one of their own had been shot. It was kind of dicey.

Then we had the security department saying, "There is no way we're going to have 20 people marauding on the MICU on the eighth floor in the tower." The nurses were like, "This is person centered care." Security said, "Well, we are responsible for the safety of . . ." Blah, blah, blah. It went on and on for six months, until finally we changed the question.

The question was: Under what conditions could we allow patients to have a visitor at their bedside? So the security force realized we weren't talking about allowing open visitation, but we said open visiting hours. We weren't very clear. They had thoughts of 20 people at each bedside all night long. They said, "Well, if there was one identified person, that's fine." That's all the nurses really wanted.

[[0:38:03]]

When we under what conditions and talked about what could work, what could you support, what could we support, we realized that there were some things in the middle that really met security's concerns and the nursing staff concerns. But we had started from such a mindset that, "Of course, you know what I'm talking about." Of course, neither side did. Under what conditions is a way to embrace paradox.

The second is to seek ambiguity. Again, this is like, "Seek it? Don't we want clarity?" Well, but, you know, ambiguity is in our world, as is paradox." Confusion endurance is in our world too. We don't have all the answers. In fact, sometimes we make decisions with 20% of the information, and we've got to feel good enough about that.

So with ambiguity, what we mean is a situation or a statement which is capable of being understood in a couple of different ways. I encounter this in my personal life a lot. I'll say something and a friend will say, "Well no, there's no way we're going to do that." Then when I explain, it's like, "Oh, that's what you meant." Words can confuse us.

A couple of examples of ambiguity. If I were to give, as I am, to you this phrase and ask you to remove six letters in sequence -- you can't jumble them up -- remove six letters and end up with a very common word. Just take out six letters. Obviously, we don't have a lot of time to do this. If anybody has seen this . . .

[[0:39:38]]

Well, take out six letters and you end up with the word banana. Don't most of us, I know I did when I first saw this, take out one, two, three, four, five, six letters, and if you had time to scramble and all that. The point being, six letters can mean different things, obviously.

[[0:40:00]]

Let me give you a couple of other examples. How is this possible?

[[0:40:10]]
- [Participant] They didn't play each other.
They didn't play each other. Very good. It took me a long time to get that. I actually had to read the answer.

Okay, how about this next one? That person can't answer. Maybe they know all these things. Some people are good at these kinds of things. I'm only kidding. How is this possible?

[[0:40:36]]
They're triplets. But see how the picture gets us moving down a certain path and limits our interpretation, just taking a look. How many times in situations do we unnecessarily limit our options because we either infer what somebody is intending, or we interpret based on our own background? I mean, that's a logical thing to do.

Here's the last one. How is this possible?

[[0:41:20]]
You push the cork into the bottle. Again, see the wording. We perhaps interpreted touching. We read remove in terms of touch, whatever. So the idea of things being interpreted in many different ways can actually be helpful. I'll give you two examples here.

What if I said to you, "I'd like you to build a door." You would say to me, "Well, okay. What should it look like?" I said, "It could look like this." You came up to me, "Well, Joanne, we don't have any lumber." I said, "But I need a door to go from this room to that room."

[[0:42:02]]
And so, what if you said to me instead of, "Okay, we're going to build a door," what if you said to me, "Joanne, would you be okay with us creating a passageway? You say door because that's what mostly connects two rooms, but would you let us play around with building a passageway or creating a passageway," in which case we could build a door. What else could we do though if we're creating a passageway?

We could have a hole. We could hang a curtain. If we were from the '60s, we could have beads. We could create a tunnel. We could create all manner of different things beyond a literal door. A glass sliding piece of glass. So that's the idea of expanding your possibilities by reframing the issue.

The second one may have more relevance because you might think, "Well, this is well and good, Joanne. These ambiguity things are kind of cute, but really, what does it have to do with real life?" I was at VCU a couple of weeks ago doing some consulting. They were talking about, "We're having a terrible time recruiting new faculty." It's hard. Many schools are faced with that.

So what we talked about, can anybody think about reframing this to give more options than just hiring new faculty? Retaining your existing faculty, yeah. What you just gave is one example of the concept. Then I'll throw it out and see what other ideas you come up with. Instead of saying we've got to recruit new faculty because we need to expand the capacity to help our nursing students learn, do you hear the difference? Recruit new faculty is a strategy. Go out and recruit. Well, good luck.
How about though, what could we do to expand the capacity to educate our students? So retaining our faculty. Other ideas you might have. Yes?

- [Participant] Engage more guest lecturers.

- Engage guest lecturers.

- [Participant] partnerships.

- Partnerships. Clinical faculty maybe coming to the school. Yes?

- [Participant] Preceptors.

- Preceptors, bringing people back, who've retired, part-time.

Somebody said to me once and I just was aware of my reaction, "Let's bring physicians in." I was like, "Oh, really? To teach nursing?" But Joanne, listen to your own advice. No, they're not going to teach the nursing theory course. But what could physicians or pharmacists or occupational therapists, they could teach our students a lot -- interprofessional collaboration, communication, physical assessment. So I was challenged myself.

Again, under what conditions? They're not going to teach the nursing theory course or nursing history. But if you reframe it, do you see all the opportunities to seek ambiguity and find a different way to frame your issue so that you're not framing the issue as the solution? Go build a door. Go recruit new faculty.

The third is to practice creativity. Now how many of you would say you're creative? Don't be shy. Yeah, two or three little hands like this. I won't do this at the end because I'll probably forget it. To say at the end of this section, everybody's hand should shoot in the air, because if creativity is the capacity to bring something new into being, aren't we challenged with doing that on a daily basis in health care?

There are a couple of myths when we think about creativity. "Well, I'm just not creative." If we're talking about bringing new ideas forward for how to even do the old things or new things that we should be doing, isn't that creativity? I would say, "Yes, it is."

It involves play and laughter. The crayons in the beginning actually are kind of a, I won't say misnomer, but it kind of reinforces the wrong idea that it's fun and we're going to make paper hats and laugh and slap each other on the back. That's creativity. No. Sometimes a faculty department chair trying to find enough faculty to teach students that are going to be showing up next Tuesday involves a lot of creativity. How do we do the almost impossible?

And then last, creativity and discipline do not mix. I would say to you creativity has to be practiced by all of us. Do we hear ourselves or anybody around us saying these kinds of things? Those are going to squash any attempt at creativity. "I'm just not creative. Go ahead, go on without me." Well, if you can't come up with any new ideas about how to do stuff, that's a problem. We have to practice it.
Here's what creativity in health care looks like, I think. Some of the work that NCSBN and the states have been doing is beyond creative. It's really futuristic in helping advance the profession and protect the public's health. You all are involved in that. I would say that's creativity in health care today. The work on transition into practice is excellent. Your simulation, social media and usage, some of the things that the organization and all of you are involved in is incredibly creative and necessary.

How do I practice creativity? There are actually some fun ways to do it, some of what we do on our own. Learning a language, today in health care, boy that would be good. I interviewed a student once and she said, "Well, I speak two languages." I was in awe because I speak half. I speak a little Spanish, but I can't understand when people speak back to me. That's why I speak half a language.

[[0:47:53]]

In Minneapolis, I said to her -- because she was trying to interview and I wanted to help her practice -- "What are your languages?" I was thinking Italian, Spanish. I didn't know what. "Somali and Hmong." Now in our community, and she's going into community mental health, is this phenomenal to prepare yourself to be effective and sought after? So learning a language.

Brainstorming uses for a common item. If we had time, could you come up with 20 uses for that picnic table? Cover in rain or a fort, or I don't know what. The point being, just challenge yourself to come up. Jigsaw puzzles. Making up analogies. One of the favorite ones we use at our school is, "Tell me what's similar between the Mall of America and nursing." Yes? Did I see a hand go up there? Any similarities between the Mall of America and nursing? Yes?

- [Participant] Busy.
- Busy, good.
- [Participant] Variety
- Variety, a lot of people.
- [Participant] the biggest of what they are.
- The biggest of what they are. Many levels, confusing. There are all manner. Somebody then said, "Okay, what about psychiatry and an oriental rug?"
- [Participant] Expensive.
- Expensive? I don't know. The point being, pick two things. I'm sorry?
- [Participant] hard to manage.
- Hard to manage, yeah. The real pattern is on the back, is not apparent. The point being, you can do a lot by making up analogies.
We had a game, not a game, but we did this with some of our faculty once. I said to the faculty, "To come to this workshop, you need to wear something you made" Some people sew and knit, so they were ready to enter. Some people were like, "I'm not creative. I can't make a thing." I said, "Just wear something you made."

[[0:49:59]]

Anybody think what some of the faculty came in with? What?

- [Participant] Cut out a paper star.
- Paper star, excellent.
- [Participant] Cookies in your pocket.
- Cookies in your pocket. A smile. One of my faculty members said, "I am going to pin two dollar bills on my jacket. That's my salary I make." [audience laughter] And she said, "I'm not kidding."

Then the best answer so far that I've heard -- although these are great answers -- is one of the students, when we did this with students, she said, "I'm going to bring one of those papoose carriers and bring my daughter."

- [Audience] Aww.
- Now wear something you made, all the different ways you could interpret that. And then stimulating a play on words. That's what that was about.

In health care now, taking these skills of embracing paradox, seeking ambiguity, practicing creativity, we know what the definition of quality is today. All eyes are heading in this direction. There's no more like, "Well, I see quality and I know it." It's like, "No." The Institute of Medicine has said, "These are the characteristics of quality." This is what we're preparing our students for. This is what regulation should help us achieve. This is what practice should be delivering. Safe, timely, effective, efficient, equitable, patient-centered.

QSEN actually had done some work on patient centered. We did educate the students because we felt they should be ready for practice. Well, we have found that the practice arena isn't always up to speed on these new definitions that have been really sponsored by the Institute of Medicine. The old definition would be listen to the patient, hear what they have to say, demonstrate respect, and then go ahead and do what we thought we needed to do for their plan. It was our plan of care.

Well, the new definition, profoundly different. Again, this is not just a group of nurses. This is the Institute of Medicine and QSEN and a lot of the national organizations. NCSBN has also been part of this since the beginning. Recognize the patient or designee as the source of control and full partner.

[[0:51:59]]

That is mind bogglingly different than what we have been doing. In fact, we'd have to help faculty and clinicians unlearn the way we have thought about patient centered or patient focused. Like a surgeon said to me, "I'm patient focused. I take care of patients." That's not what this means. Source of control and full partner and then with the other kinds of components.

If I look at your website and your purpose, "to protect the public's health and welfare by assuring that safe and competent nursing care," and we saw what competent means so that those elements are being demonstrated with
leadership, "is provided by licensed nurses." As an organization, you already have said, "We have a stake in protecting the public, person, patient-centered care."

Henneman and Cardin many years ago said, "Patient-centered care really is not adequate. We should say family-centered care or patient family-centered care." Again, this is very much a nursing approach. We know that it's not just the individual we're working with. It's their family, whoever they define that as. The idea of patient and family or family-centered care has been appropriately gaining momentum.

But there are many of us -- and this is the one slide you'll see about the book -- that believe that's not even far enough. We've got to go to person and family-centered care. Why is that? Here are the dimensions of, back in the day, patient and family -- Respect the patients' values, coordination. So these six elements really are the essence of person and family-centered care.

This groundswell nationally, and actually internationally, the Swedish Nurses Society adopted the QSEN competencies and said, "That patient centered care is a little too old. We're going to change it. Do you mind?" They now have their one competency is person and family-centered care. So we learned from them.

These dimensions are consistently identified as the elements of patient or person centered care. But the reason we felt the change was needed to be encouraged as we worked to help the individual and their designee to be a source of control and full partner -- and we are so far away from that in health care -- that many people receiving care today aren't in hospitals. To call them a patient if they're walking around and fully employed seems a little narrow.

People like myself, I had cancer 15 years ago. I don't see myself as a patient. I have a chronic illness, but I don't see myself as a patient. I want to be a partner with my caregiver. Fortunately, I'm working with some who get that concept. Even if somebody is in a hospital, and again if you're in the middle of the ICU, fine, they probably are in the ballpark of being considered a patient, but the word "patient" is too narrow for the multiplicity of sights and settings and tools that we're using.

So the idea of a partner really has to be emphasized. This quote on the cartoon you can't see is the physician standing at the bedside saying, "Get to know us." The patient in the bed is saying, "Get to know me first." The idea that they want to be known as a person first.

The explosion of materials, on the left is a book recently out by Eric Topol. "The Patient Will See You Now." On the right, this was in Forbes, but also in Health Affairs within the past year: "Patient Engagement is the Blockbuster Drug of the Century." Only with active involvement and partnership with individuals and their families will we reduce the 400,000 deaths that are occurring per year that have been based on the evidence that's been compiled, compared to the 98,000 we thought we were dealing with, which was horrific enough.

What's different here, and I think at this point in time and as nurses we are so well-equipped to really take the lead in partnering with individuals and their families is that we recognize there are individuals and families that
need to be partnered with and helped to be the source of control. That doesn't mean that they're going to do their surgery. That doesn't mean they're going to decide what drugs to take afterward.

They are going to have serious, crucial conversations with their providers about, "That drug always makes me sick. I just don't think I should take that," short of an allergy, "but that's not going to work for me." Or to the guy with the shoes, "It's not going to work for me to use a scale." Personalizing the care.

Yesterday when we talked about the restaurants, what occurred to me is what we're talking about in health care are high reliability organizations. That's what we're aiming to develop in health care and have you help us reinforce, because your job is not to regulate or to put pressure on organizations. If nurses are practicing within a wide variety of organizations and across states, how do we then coordinate that?

This is a couple of comments about high reliability organizations. This is what we mean. It's very similar to the idea of the restaurant, really focusing on a couple of things, relentless pursuit of quality and safety, and creating an environment where people can speak up and say, "This doesn't seem right. I'm so sorry, this is not what we should be doing."

A lot of forces within health care say, "We want to be involved as patients, as consumers, and as individuals." Again, it's not just a nursing initiative. A lot of standards, national organizations. Again, as nurses, wouldn't we really want this to be happening? These other groups are saying for their purposes and their reasons, "This is the direction we should be moving."

We have standards. We have leadership. We have new ways to think. The question obviously for this organization and all of you is, "How do you partner in different ways with the communities that you serve?" I mean the community in terms of the public.

[[0:58:01]]

How do you partner? How do you bring those people on your boards? How do you give evidence that this is something that you are helping advance because it's such a part of the national initiative. A lot of examples about what could person and family-centered care look like. This is where I sit on their board, but so many organizations are saying this is the right thing we have to do.

Again, not just hospitals, not to be hospital centric, but in homes and to make sure that we have learning centers and videos. Last week, I was at a clinic down in Florida. I had a cold. I wish they had educational videos about all the people that are sitting there who are coughing and sneezing all over me while we're sitting in there waiting to be seen in the waiting room. Wouldn't that be a perfect learning opportunity?

In conclusion, nurses are the foundation of the healthcare system. Health care is different today. People will be involved. We can either partner with them. We are increasingly wanting to be engaged and involved. You could use your nursing lens. Sometimes it starts with a cup of coffee with somebody you don't really agree with.

At the end of the day, who are we as nurses? Well, according to two of my idols, Donna Diers and Claire Fagin, "Tough, canny, powerful, autonomous, heroic," and I say effective today. Maybe my favorite quote I'll leave you with is from a Boston cab driver when I told him I was a nurse. He said, "Ah, nurses, caring, shrewd, a little bit crazy." [audience laughter]
Thank you.

[applause]