

From the Editor-in-Chief

Being in the Middle

After many days of seemingly endless, warm sunny weather, I have spent what seems like countless hours catching up on long-awaited good reads but also ruminating on issues of the day – social, professional and, inevitably, what to write about in this editorial. By the time you read this latest instalment, the summer will be over, seasonal change will be evident and the warmth of this day a distant memory, but the issues associated with “being in the middle” will undoubtedly remain unresolved.

In my last editorial, I suggested that the profession needs to get a steadfast grip on setting a sustainable course for the future and delineating the roles that nurses will play in the healthcare system. Reflecting on the evolving roles of nurses in the past and present gives me reason to believe that the possibilities for the future are plentiful. The much-touted need to reinvent the healthcare “system” presages role expansion and optimization opportunities for nurses. But at this time, it is also clear that some roles may be imminently at risk and more urgently in need of rethinking than others.

Take, for instance, the role of the nurse manager, aka “head nurse” of days gone by. Over the last 20 to 30 years, the scope of this role has continued to expand with the addition of more and more responsibilities and accountabilities. Managing large teams of people (for some, more than 100 to 150 staff these days), budgets in the millions of dollars, complex technologies and material resources, and complicated day-to-day clinical operations requires nothing short of a herculean effort. We know, anecdotally and empirically, that staff desire strong, visible leadership, that large spans of control compromise capacity, that managers need time to lead and that patients and families need to know who is ultimately in charge. We also know that the nurse manager is more often than not caught in the middle, seeking the balance between staying on budget and ensuring sufficient staffing to deliver safe, high-quality care.

It is a role that has been on my radar for awhile, given that many of my graduate students are in such positions and often discuss the challenges of their day-to-day world. Our discussions have often centred on issues of being in the middle, overburdened with competing tasks and agendas, and the painful absence of much-needed mentorship and coaching. Inherent in many comments are sentiments of a thankless job that necessitates serving multiple masters – meeting the expectations of senior executives, ensuring that contractual obligations are met, keeping

staff and physicians content, and all the while meeting the needs of patients and families. Over the years, I've heard managers refer to themselves as the "mother confessor," "referee," "peacemaker," "counsellor" (career and otherwise) and any euphemism you might imagine for efforts to keep someone or everyone happy. A seasoned nurse manager once described her daily work to me as being akin to "being a sitting duck in a shooting gallery." Despite these laments, managers also describe the rewards; you can likely recall examples when being in the middle offered a satisfying mediation or coaching moment. But consider the impracticality of coaching, developing and providing meaningful performance feedback to dozens of staff, some of whom the manager rarely sees.

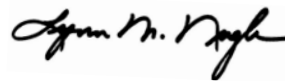
The nurse manager's role reminds me of the predilections associated with one's birth order, in particular, that associated with being the middle child. Being the eldest of nine children, I recently asked my "middle child" sister about her life experience. In her words, being in the middle means "being a pleaser." Sound familiar? You have to account to the senior while taking responsibility for the junior (I won't tell you what she actually said about the challenge with her eldest sibling). In the case of middle managers, not only do they have multiple responsibilities, they need to ensure that they deliver upstream results all the while leading, managing and developing a team that delivers downstream.

In this issue, Udod and Care (2011) raise further questions about the stress and coping experiences of front-line nurse managers. The issues uncovered in their work and others underscore the significant attention that needs to be directed to this particular role. My interview with Dr. Bourne highlights the challenge further, an unsolicited validation of the importance of leadership at the point of care (Nagle 2011). In Ferguson-Paré and Harris's report (2011) of the first National Nursing Executives Summit, the importance of the first-line manager was a point of discussion during those deliberations. Simpson and colleagues (2011) also point to some of the as yet unanswered questions about leadership development – who, how, when and where. It is clear that more research is needed, but we already have a sufficient knowledge base to begin to consider what needs to be changed to improve the likelihood of aspiring managers' success.

Harkening back to personal experience and those recounted to me by others over the years, the individual identified to have the most impact on the impressionable, freshly minted graduate nurse has been the immediate supervisor. This person is most likely to hire you into your first real nursing job and set the course for your professional growth and development – or not. To this day, I can vividly recall my first "head nurse" and those that followed thereafter – some good, some not so good – the good for having and taking time to lead, and the not so good for having to deal with too many competing, if not conflicting, agendas.

Perhaps it is time to consider a new model of middle management that reallocates some of the responsibilities currently within the purview of nurse managers. While different models of non-nurses managing clinical units have been tried with varying degrees of success, this is not reason enough to simply hold on to traditional models. Staff nurses and advanced practice nurses, in particular, are well positioned to offset some of the clinical oversight responsibilities of nurse managers. And maybe it is time to rethink other roles, including clerical, as today's administrative and clinical practice has different support needs. It's time to become creative in designing leadership models. If we truly believe that leadership is a shared responsibility, we need to create models that meet the needs of managers as well as developing the staff who report to them. Most importantly, we need to create roles that have realistic and manageable expectations.

I fear that nurses will continue to be put in management positions of irrational scope and scale. In recent times, these positions have made leadership effectiveness and, surely, job satisfaction fleeting. More importantly, the word is out, and to quote one of Udod and Care's study participants: "It's a thankless job. You get dumped on from above, and you know the people underneath you aren't happy, but there's nothing you can do about it ... years ago it was the prize job" (Udod and Care 2011: 67). Given that being nurse manager is no longer the "prize job," the impact on new graduates of losing the potentially powerful influence of this role is worrisome. In order to attract leadership talent in the years ahead, it is imperative to create management roles that are more manageable and truly nurturing of the leadership we want to see flourish into the future.



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