THE ISNA BULLETIN

INDIANA NURSES FOUNDATION

ISNA INDIANA STATE NURSES ASSOCIATION

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November 2014

Message from the President

Jennifer L. Embree, DNP, RN, NE-BC, CCNS

As I spent the summer investigating how to best plan for leadership education for future executive nurse leaders, I had the opportunity to engage in a workshop with busy professionals external to health care. We were all interested in discovering our styles and enhancing our external and internal images. Intrigued as always by meeting new people; I listened attentively to the stories of these new colleagues. I also thought about first and lasting impressions of professionalism for nurses.

I am of the impression that we as nurses do not always enhance our personal leadership talents when we receive additional education, I wanted to focus on my own personal development, to see what I needed. (Thinking, how can I encourage others when I am not at my best?) I also wanted to learn how best to help others enhance their personal strengths. Sometimes when we are very busy, we tend to glance over areas for improvement, thinking we do not have time to really commit to frivolous things like the first impression others have of us. But as nurses we have to be believable, credible and respected. Does it matter that I have nurse presence? How do we as nurses measure up next to other health care professionals?

Do we really have time to reflect upon self improvement? Can we afford not to see ourselves measured next to others? According to the Institute of Medicine, we are slated to lead healthcare changes. As 3.1 million proud, are we equally representative of each other? See one nurse, seen all nurses?

Operating in a flipped classroom atmosphere (or doing reading and personal work prior to attending this workshop), I was interested in where my interests were and in that how I presented myself was not always in line with my personal expectations! Could it be that I hindered my own success by how I looked? As we change our roles as nurses are we stepping up our game? Are we dressing to be more impactful?

Are we more concerned about exemplifying our individuality versus using all of our talents to best present ourselves? Are we saying "I have great nursing skills, appearance is not important!" My friend and Image Consultant, Solo Adelowo, provides three tips to others about their image. The first tip is to dress for your goal. Knowing your goals will be different at work, with your friends, and at home, investigate what your goals are for each environment that you live in (Adelowo, 2014). Do you want to escalate your career? Do you want to be a role model for your friends, family, and those you coach? Are you ready to ease back into retirement? Defining your goals for each area of your life provides you with clarity and helps support your success in life.

Knowing your audience is the second tip that Solo offers and it helps you define that you are dressing the walk! Are you being complimented about any aspect of your appearance? When your appearance is appealing, you start to gain other people's trust, which is important for earning credibility. To appear appealing ensures that what you are wearing and how you appear makes sense for the occasion, time of day, or environment. When you meet your audience's visual expectations it is easier to gain attention and enhance your credibility (Adelowo, 2014). "But I can only wear scrubs, you say to me!" Even with scrubs, you can look like stunning! I remember the first day a healthcare organization required a consistent dress code. Confidence and professionalism was exuded by those nurses! Do you want to be the nurse that carries him/herself well, who is put together well and whose appearance screams "Professional?" Nurses are the most trusted profession, but the literature says that we still have difficulty with our image (Wocial et al, 2014). Maybe Sola's tips have great value!

Sola's third tip is to accommodate your body type. When you dress for your body type, your overall appearance is proportionate and balanced. Choose clothes that fit and flatter the body you have today. Sometimes we keep clothing sizes we would love to fit into, but we do not. Let them go! (After attending this workshop, I banished three huge bags of clothing from my closet to those in need.) Did you know that there are no standards for sizes (Is that a relief?) (Adelowo, 2014)? Try everything on and choose the clothes that fit your body with ease. I had a really bad habit of not trying clothes on and buying them. When I would try them on at home, it was not a pretty sight and back to the store with those outfits! When your clothes fit and flatter your body you are more comfortable and you appear more attractive. And when you appear attractive, looking at you will be a pleasant experience and you will look more credible. Are you able to change your credibility?

As changes occur in your life, so you must adapt. As a leader and a nurse, being adaptable is required. What do you want to be remembered for? As nurses, we are servant leaders. To be servant leaders, we must be credible and many times must ask for funding for important projects that help support our work, our communities, and the missions we take on. Are we credible enough for people to believe in us? How can we each improve how we appear?

Do you have a personal brand? A brand is the perception and experience of someone (Wocial et al, 2014). A brand can be tangible and intangible attributes that are distinguishable (Wocial et al, 2014). Can we tell one nurse from another nurse? A brand is also a promise reflected in the mind of your viewer (Wocial et al, 2014). Do you have a personal brand of assurance that inspires confidence and alleviates fears (Wocial et al, 2014)? It is time to start letting that brand shine! Who better but the most trusted profession, the Indiana nurses! How better to show our solidarity than by becoming an ISNA member?

CEO Note

How We Become Leaders

Gingy Harshey-Meade, MSN, RN, CAE, NEA-BC

Leadership is a funny thing. Is it in the genes? From the environment? Are you taught how to be a leader? Can it be learned? So the big question is, are leaders born or made? Now this question has never kept me up at night but I have actually thought about it. I was born the oldest of eight so by birth placement, I could argue, I was born a leader. But when I am honest with myself I remember that some of my siblings didn't always follow my leadership so I needed some help. So having given it thought here goes:

I believe leaders are usually bright, they have a presence that makes others want to follow. Most of all I believe leaders have a responsibility to know of what they speak and to not lead others where they don't want to go. So my observations are truly good leaders come with all four attributes:

They are bright;

They come from an environment that helps the individual develop into a leader;

They have been mentored by others; and,

They have the capacity to learn.

So why do I care? Well I believe our profession requires leadership skills. We want our patients to follow our directions. That takes leadership. We want our colleagues to listen to us and respect our thoughts. That takes leadership. You think I am wrong? Well here is a definition of leadership:

Leadership – *"a process of social influence in which one person can enlist the aid and support of others in the accomplishment of a common task."*

To me that sounds like every nurses desired outcome. So now go forth and lead!

Indiana Nurses Foundation

The Indiana Nurses Foundation (INF) is the Foundation of the Indiana State Nurses Association (ISNA). It exists to be the philanthropic arm of ISNA. The Foundation has been dormant for a few years but ISNA is committed to having a robust Foundation which provides additional avenues to enrich the nursing profession of Indiana. If you are a member of ISNA and would be interested in assisting in the rebirth of INF please contact the ISNA office at 317-299-4575 or gingy@indiananurses.org.

Gingy Harshey-Meade MSN, RN, CAE, NEA-BC
Chief Executive Officer

INF
INDIANA NURSES FOUNDATION

THE BULLETIN

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Web site: www.indiananurses.org

ISNA Mission Statement

ISNA works through its members to promote and influence quality nursing and health care.

ISNA accomplishes its mission through unity, advocacy, professionalism, and leadership.

ISNA is a multi-purpose professional association serving registered nurses since 1903.

ISNA is a constituent member of the American Nurses Association.

Bulletin Copy Deadline Dates

All ISNA members are encouraged to submit material for publication that is of interest to nurses. The material will be reviewed and may be edited for publication. To submit an article mail to The Bulletin, 2915 North High School Road, Indianapolis, IN. 46224-2969 or E-mail to info@indiananurses.org.

The Bulletin is published quarterly every February, May, August and November. Copy deadline is December 15 for publication in the February/March/April *The Bulletin*; March 15 for May/June/July publication; June 15 for August/September/October, and September 15 for November/December/January.

If you wish additional information or have questions, please contact ISNA headquarters.

www.indiananurses.org

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ISNA
INDIANA STATE NURSES ASSOCIATION

The ISNA is a Constituent Member of the American Nurses Association

APPLICATION FOR RN MEMBERSHIP in ANA / ISNA

Or complete online at www.NursingWorld.org

PLEASE PRINT OR TYPE

Last Name, First Name, Middle Initial

Name of Basic School of Nursing

Street or P.O. Box

Home phone number & area code

Graduation Month & Year

County of Residence

Work phone number & area code

RN License Number State

City, State, Zip+4

Preferred email address

Name of membership sponsor

1. SELECT PAY CATEGORY

_____ **Full Dues – 100%**
Employed full or part time.
Annual – $281
Monthly (EDPP) – $23.42

_____ **Reduced Dues – 50%**
Not employed; full-time student, or 62 years or older.
Annual – $140.50
Monthly (EDPP) – $11.88

_____ **Special Dues – 25%**
62 years or older and not employed or permanently disabled.
Annual – $70.25

2. SELECT PAYMENT TYPE

_____ **FULL PAY – *CHECK***

_____ **FULL PAY – *BANKCARD***

Card Number

VISA/Master card Exp. Date

Signature for Bankcard Payment

_____ **ELECTRONIC DUES PAYMENT PLAN, MONTHLY**

The Electronic Dues Payment Plan (EDPP) provides for convenient monthly payment of dues through automatic monthly electronic transfer from your checking account.

To authorize this method of monthly payment of dues, please read, sign the authorization below, and enclose a check for the first month (full $23.42, reduced $11.88).

This authorizes ANA to withdraw 1/12 of my annual dues and the specified service fee of $0.50 each month from my checking account. It is to be withdrawn on/after the 15th day of each month. The checking account designated and maintained is as shown on the enclosed check.

The amount to be withdrawn is $_____ each month. ANA is authorized to change the amount by giving me (the under-signed) thirty (30) days written notice.

To cancel the authorization, I will provide ANA written notification thirty (30) days prior to the deduction date.

Signature for Electronic Dues Payment Plan

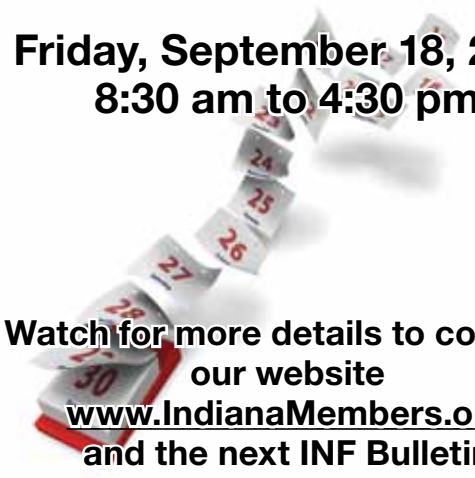
3. SEND COMPLETED FORM AND PAYMENT TO:

Customer and Member Billing
American Nurses Association
P.O. Box 504345
St. Louis, MO 63150-4345

SAVE THE DATE

for our upcoming 2015 ISNA Meeting of the Members

Friday, September 18, 2015
8:30 am to 4:30 pm



Watch for more details to come to our website www.IndianaMembers.org and the next INF Bulletin

Certification Corner

Sue Johnson

I have worked as a Magnet appraiser for many years. I enjoy the opportunity to see excellent facilities and meet talented nurses and nurse leaders throughout the country. Recently, I participated in a site visit in another state. I was impressed with the emphasis the hospital and nurse leaders placed on certification. Since preparation for specialty certification is frequently not available in the local area, the facility's executives and nurse leaders pay for certification preparation courses using outside experts. This approach enables more staff nurses to attend these classes as they prepare for the testing process. Needless to say, this results in a significant expenditure by the facility to bring in noted experts, as well as, paying for nurses to attend the courses.

Many nurses expressed thanks for this support along with pay for testing, certification pay and recognition. The certified nurses who we met were articulate about how certification has benefitted them and their patients. They truly believe certification makes a positive difference in patient care and, according to the patients we spoke with, they are right.

I have always been proud to be certified. I wish every nurse could hear the stories of these staff nurses. If you have been considering certification, take that step—for yourself and your patients!

Do any of you have certification stories you'd like to share? Contact me at SueJohn126@comcast.net and I'll be glad to publish your comments.

Advocacy

Policy Primer

Blayne Miley, JD
Director of Policy & Advocacy
bmiley@indiananurses.org

I hope you all voted in the election this month. Moreover, I hope that isn't the extent of your involvement in the policy world for the next year. Policymaking is not pumpkin spice. It's year round, not seasonal. The next issue you receive of the INF Bulletin will be in February, and by then the Indiana General Assembly will be running at full speed. You'll receive a summary of the bills most material to nursing, some of which will already have had committee hearings. The 2014 General Assembly session had 870 bills introduced, 224 of which became law. That was a short session. The 2015 General Assembly will be a long session, because the legislature will be putting together the biennial budget, and I expect over 1,000 bills to be introduced. Every year Indiana law is changed in ways that materially impact you personally and professionally. Shouldn't you be involved in the discussions that shape your world? Participate by contacting your state legislators to share your expertise.

ISNA members will get weekly details of all the introduced bills that impact nursing through the ISNAbler, our weekly e-newsletter. Speaking of the ISNAbler, it's redesigned, now with a more mobile-friendly look and a weekly Poll Position question to gather input from ISNA members. Poll Position joins Affordable Care Actions, your weekly update on ACA implementation, as a regular feature. Speaking of redesigns, the ISNA website has a new look too; check out the improvements at www.indiananurses.org!

Policy Is More Than Just Politics

Being involved in policy includes helping to shape your workplace policies and procedures. Their importance has been reinforced by the developing Ebola situation. To share and echo the words issued by the American Nurses Association, "as the Ebola situation continues to evolve, we commend nurses and other members of the health care team for their vigilance, dedication and commitment to providing excellent care to all patients. We also send our sincere wishes for a swift and full recovery to nurses Pham and Vinson. We remain steadfast in supporting the two nurses, their families, colleagues and communities." The relevance of infrequently used procedures suddenly has national prominence. The information and advocacy tools ISNA provides are applicable to workplace policy involvement, as well as legislative issues. Your advocacy can improve your world by changing a procedures manual just as much as it can by changing Indiana law.

Interim Study Committees

The Interim Study Committees have finished their meetings, giving us a preview of a few topics that will be the subject of bills in the 2015 Indiana General Assembly. The Public Health, Behavioral Health, & Humans Services Committee studied a variety of topics, but only reviewed preliminary drafts of two bills. First, a bill establishing a pilot program to reduce Medicaid spending on the top 10% users in the program. The pilot would provide care coordination services and limit the available network in an effort to reduce costs. Second, a bill designed to make prescription eye drops more consumer-friendly by allowing for early refills and additional units. Patient difficulty with administering prescription eye drops can lead to a 30-day supply being used up in a shorter timeframe, and multiple units allows for patients to have the medication in multiple locations to increase compliance with the recommended dosage.

The Committee on Fiscal Policy was assigned to study multiple topics on the implementation of the Affordable Care Act in Indiana. The Indiana State Department of Insurance testified before the committee, and here is a summary:

(1) Current operation of the federal exchange in Indiana
  (a) The rollout of the federal exchange had several problems, which led to the state high-risk pool being extended for an additional month at a cost of $6.3 million to the State.
  (b) 132,423 Hoosiers enrolled in a plan under the health insurance exchange, and 89% of them received financial assistance through tax credits or cost sharing reductions.
  (c) The 2015 open enrollment period is November 15, 2014 – February 15, 2015. Of concern is the open enrollment period is 3 months, which is materially shorter than the 195 day period for 2014.
  (d) Another concern is consumers renewing the same plan for 2015 that they purchased through the exchange in 2014 could face increased premiums due to the benchmark plan for calculating federal tax credits changing. Consumers need to shop around.

(2) Whether Indiana should implement a state-run health exchange
  (a) Sixteen states plus the District of Columbia have state-run exchanges, and many of them experienced similar problems as the federal exchanges.
  (b) The cost of developing a state-run exchange was estimated to be $30-$40 million annually, not including development costs of approximately $40 million. Indiana could have imposed a fee to run the exchange, which would have been passed on to consumers.
  (c) The Department of Insurance will continue to license insurers and review their rates and forms before they may be offered in Indiana.
  (d) If the State operated its own health insurance exchange, Indiana could determine the enrollment periods.

(3) Definition of "essential health benefits" for use in Indiana under the ACA, including ensuring that the definition results in adequate benefits
  (a) Indiana can define "essential health benefits" differently than other states, although it must be benchmarked to a typical plan.
  (b) Presently, Indiana uses the largest small group plan (by enrollment) to define essential health benefits. Indiana's benchmark cannot be changed until 2016.

(4) Access to consumer choice of health care providers.
  (a) The primary responsibility for assuring network adequacy is still with the federal government. The State is hoping to make provider information more available, and the State is planning more consumer outreach to help consumers.
  (b) In 2014, the largest plan available in Wayne County did not include the local hospital and the network for Monroe County did not include a local hospital for delivering babies.
  (c) There will be 9 providers on the 2015 Indiana health insurance exchange, up from 3 in 2014.
  (d) There will be 975 plans in 2015, up from 278 in 2014.
  (e) Under the Healthy Indiana Plan 2.0 proposal, providers are reimbursed at Medicare rates, leading to greater access to health care services.

Healthy Indiana Plan 2.0

As of mid-October, Indiana was still waiting to hear from the federal government whether approval would be granted for the Healthy Indiana Plan 2.0 proposal, which would expand HIP to cover the eligibility pool of the proposed Medicaid expansion in the Affordable Care Act. A yes would mean approximately 348,900 Hoosiers gaining health insurance assistance, and would also mean HIP 2.0 replacing traditional Medicaid for all non-disabled Hoosiers age 19-64. A no would mean either the current version of the Healthy Indiana Plan continues for another year, or goes away entirely.

Get Involved!

I encourage all of you to be engaged in policy. It affects you personally and professionally, and you have valuable contributions to make to the conversation. ISNA is here to offer support, so let us know if we can be of assistance!

Independent Study

Developing a Nursing IQ - Part 1
Characteristics of Critical Thinking: What Critical Thinkers Do, What Critical Thinkers Do Not Do

This independent study has been developed to provide nurses with an overview and introduction the characteristics of critical thinking. 1.4 contact hours will be awarded.

The Ohio Nurses Association (OBN-001-91) is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.
Expires 9/2015.

DIRECTIONS

1. Please read carefully the attached article entitled, "Developing a Nursing IQ – Part I: Characteristics of Critical Thinking: What Critical Thinkers Do; What Critical Thinkers Do Not Do."
2. Then complete the post-test.
3. The next step is to complete the evaluation form and the registration form.
4. When you have completed all of the information, return the following to the Indiana State Nurses Association, 2915 N. High School Road, Indianapolis, IN 46224
    1. The post-test;
    2. The completed registration form;
    3. The evaluation form; and
    4. The fee: $20.00

The post-test will be reviewed. If a score of 70 percent or better is achieved, a certificate will be sent to you. If a score of 70 percent is not achieved, a certificate will not be issued. A letter of notification of the final score and a second post-test will be sent to you. We recommend that this independent study be reviewed prior to taking the second post-test. If a score of 80 percent is achieved on the second post-test, a certificate will be issued.

If you have any questions, please feel free to call Marla Holbrook, Indiana State Nurses Association at mholbrook@indiananurses.org or 317-299-4575.

OBJECTIVES

Upon completion of this independent study, the learner will be able to:

1. Define critical thinking.
2. Identify universal intellectual standards and cognitive skills as they apply to critical thinking.
3. Contrast positive versus negative essential intellectual traits.
4. Recognize characteristics that prevent or hinder critical thinking.

This independent study was developed by: Barbara G. Walton, MS, RN, NurseNotes, Inc. The author and planning committee members have declared no conflict of interest.

There is no commercial support for this independent study.

Disclaimer: Information in this study is intended for educational purposes only. It is not intended to provide legal and/or medical advice.

I. Introduction

This begins a series of self instructional modules regarding critical thinking. The modules are best completed in order, but it is not necessary to do so. In this module we will be discussing characteristics of critical thinking. We will examine things that critical thinkers routinely do versus things that prevent critical thinking. In subsequent modules we will explore both the art and science of nursing and how critical thinking is key to good nursing practice. We will explore how we develop a "Nursing IQ." We will also visit ideas to assist other nurse colleagues in developing their Nursing IQs. In other words, how do we teach people to become critical thinkers? Finally we will touch on how critical thinkers are a crucial component of a culture rooted in safety. Ever since the 1999 study released by the Institute of Medicine that stated healthcare institutions kill as many as 90,000 patients every year, we have become more safety focused. But what progress have we really made in ten years? What more needs to be done? We need critical thinkers! Along the way to developing successful intelligence and creating a culture of safety, we will delve into the works of Patricia Benner, Edward Bloom, Daniel J. Pesut, Joanne Herman, Gaie Rubenfeld, Barbara Scheffer, John Nance, and Robert Sternberg, just to name a few.

First we will look at characteristics of critical thinkers and things critical thinkers routinely do in the process of thinking critically. We will examine the intellectual traits and virtues that enhance critical thinking. Next we will explore those things that prevent critical thinking, or the things critical thinkers routinely do not do. As you read this module, think about your own thinking. How many of the traits of a critical thinker do you already possess? What traits do you practice that prevent you from being a critical thinker? Thinking about one's thinking is called *metacognition*. Interestingly, metacognition is a form of critical thinking. To be aware of and purposeful in one's thinking and one's response to thoughts, is a characteristic of critical thinking. So, here before we've barely begun, you are already practicing critical thinking! So let's put on our thinking caps and begin to develop our Nursing IQ's.

"Shall I tell you what it is to know? To say when you know, and to say you do not when you do not, that is knowledge." ~ Confucian Analects as cited in Do-Sai, 1880.

II. Characteristics of Critical Thinkers

A. Critical Thinking Defined. There are many *definitions of critical thinking.* One definition comes from Richard Paul and Linda Elder of the Center for Critical Thinking and states "Critical thinking is the art of analyzing and evaluating thinking with a view to improving it. Critical thinking is self-directed, self-disciplined, self-monitored, and self-corrective thinking." Another way of looking at this definition is that critical thinking is being mindful. *Mindfulness* means you are engaged with a certain activity, focused and actively thinking about whatever it is you are undertaking at the moment. Mindful is what I want my nurse to be when she is administering medications to me. Mindful is what I want my surgeon to be when undertaking a surgical procedure on me, or my loved one.

In other words, I would like these individuals to be engaged and critically thinking when undertaking my care or caring for a loved one. We already know the outcomes of *mindlessness*. Mindlessness occurs when one is not paying attention to the task at hand, or is not engaged in active thinking about the task at hand. How many people, distracted by something else, make errors? How many traffic accidents are there because someone was not mindful when they are driving? They are driving at 80 miles per hour in heavy freeway traffic, talking on the cell phone, radio blaring and drinking a cup of hot coffee. This is not the picture of a mindful driver! Mindlessness creates errors and is costly beyond measure. Mindlessness or lack of critical thinking is what lies at the core of the Institute of Medicine 1999 study that stated we kill some 90,000 patients every year due to errors.

How many patient deaths could have been prevented if all healthcare professionals and all those engaged in the business of healthcare had been engaged in critical thinking? In critical thinking, we raise vital questions and define problems clearly and precisely. Critical thinking healthcare professionals gather and assess relevant information and come to well-reasoned conclusions. Critical thinkers identify solutions, give consideration to alternatives and communicate effectively with others in an effort to solve the problem at hand. Let's look at some specific traits of critical thinkers.

B. Universal Intellectual Standards. These are standards that become fused in the thinking processes of a critical thinker. For critical thinking nurses, these standards become part of our inner voices and guide us as we go about caring for our patients. The use of these standards is not limited to only our nursing practice. Individuals, who utilize these standards, use them in all avenues of their lives. The **Universal Intellectual Standards** are as follows:

Clarity: This is the gateway into critical thinking. If something is unclear, it is difficult to proceed. We don't know what is relevant or accurate if information is unclear. Having a clear picture of the patient's problems certainly makes it easier to help solve the problem. How often do you clarify information from patients by asking for descriptions or for more information? We clarify physician orders. What happens when information is not clear? This is an essential component of not only nursing assessment, but having clear information assists us in making sound nursing judgments and clinical decisions. Questions to ask or consider to achieve clarity include:

- Could you give me an example?
- Could you give me more information?
- Could you elaborate?

Accuracy: Statements or information may be clear, but not true. For example, "All physicians are pompous." The meaning is certainly clear, but certainly not true. Accuracy can be problematic when we misinterpret what patients tell us. We often use clarity to assure we have accurate information. Questions to ask or contemplate to achieve accuracy may include:

- How can I check on this?
- How can I verify this information?
- What other information do I have that may dispute or confirm this?

Precision: Precision has to do with exactness or specifics. Statements can be both clear and accurate, but not precise. For example "Mary is overweight." This is clear and may be accurate, but it is not precise, as we do not know how overweight Mary is. Is she 10 pounds or 100 pounds overweight? Precision gives us more details. With more details we can make better clinical decisions. Questions to ask or think about to achieve precision include:

- Could you give me more details?
- Could you be more specific?
- Could you be more exact?

Relevance: Is the information relevant to the problem or task at hand? Relevance has to do with significance. A statement may be clear, accurate and precise, but not relevant. For example "Mrs. Jones has a throbbing pain in her left hand as evidenced by her facial grimacing and guarding of the hand. She states it is a pain level of 8 on a scale of 10 and she has had no bowel movement today." The information regarding the bowel

Independent Study continued on page 7

Independent Study continued from page 6

movement is not really relevant to the issue of Mrs. Jones' left hand. Nurses are constantly sorting relevant from irrelevant information. Honing in on relevant data further assists us in nursing practice. Questions to ask or think about to achieve relevance include:

- How is this information connected to the problem?
- How does this information help me with this issue?
- Does this information pertain to this problem or another problem?
- What significance is this information?

Depth: What are the other complexities involved in this particular issue? Are you attempting to deal with a very complex problem in a superficial manner? For example Ms. Treetmint has been a victim of spousal abuse for quite a few years and she is told to "Just leave him." That is a very simplistic solution to a very complex problem. While the statement "Just leave him" is clear, accurate, precise and relevant it does not give consideration to the depth of Ms. Treetmint's problems. Questions to contemplate or ask to achieve depth include:

- Are you dealing with all significant factors?
- What are the difficulties we need to consider or deal with?
- What other issues factor into or contribute to this problem?

Breadth: Taking into consideration other points of view is what is meant by breadth. One nurse may be thinking the abuse sustained by Ms. Treetmint was her own fault, brought on by herself. Whereas another nurse would consider self-esteem issues, lack of monetary support and being jobless as factors adding breadth to Ms. Treetmint's problem. Questions to ask or think about to achieve breadth would include:

- Do we need to look at this from another perspective?
- Is there another point of view to consider?
- Let me consider the point of view from Ms. Treetmint's vantage.

Logic: Logic has to do with making sense. Logic is when we bring together a variety of thoughts into some order. When combinations of thoughts come together and are supportive, the thinking is considered to be logical. For example Mrs. Jones is complaining of her left hand throbbing with a pain level of 8 on a scale of 10, yet she is seen laughing and clapping her hands while viewing a television show. Her described behaviors while watching TV are not congruent with the complaints of relatively severe pain. Her behaviors are not logical, or do not support the complaints of pain. If she had been described as sitting quietly, guarding the hand, keeping her eyes closed and minimally moving, that would be more congruent or logical information fitting for someone experiencing pain. Questions to consider or ask to achieve logic include:

- Does this make sense?
- Is the information I have congruent?
- Is the information I have conflicting?

Nurses who are critical thinkers value and adhere to these intellectual standards. These intellectual standards are part of the nurse's thought processes as he or she makes determinations about patient care. Critical thinkers do not spend time on the trivial or irrelevant. Nurses who are critical thinkers are truth seekers, who demonstrate sensitivity to the views of others, are open-minded and are sensitive to the potential of their own biases. For example while the individual nurse would "just leave him" to eradicate herself from an abusive situation, she also realizes Ms. Treetmint's situation may be very different from her own life situation, and is able to overlook her own bias in assisting this patient.

Critical thinking, mindful nurses value and often thrive on intellectual challenges. Mindful nurses are self-confident in their well-reasoned thoughts because the nurse has developed nursing skills as well as thinking skills. Mindful nurses believe that nursing is never superficial or meaningless. Thinking nurses realize the significance of what they do and appreciate that they must be actively engaged with the practice of nursing. Pursuing tasks without thought only culminates in poor practice. Think about some of your colleagues. Perhaps some of the examples used reminded you of co-workers. Which colleagues do you think of as being mindful? Why is that? Do you see evidence of these nurses using or role modeling these intellectual standards? What about nurses you do not consider to be mindful or critical thinkers? What intellectual standards are lacking in these nurses? Think about yourself for a moment. Do you readily make use of these standards in your own thinking? Which standards do you use? Which ones do you not use, but will make a conscious effort to incorporate in your practice? Knowing about these standards gives us terminology. We can use the terminology to then identify the standards when we use them or when we see a colleague use them. It also gives us the means to identify negative traits that we can self-correct.

C. Essential Intellectual Traits. These are traits or characteristics of critical thinkers. Again, critical thinkers routinely demonstrate these traits in all aspects of their lives, not just professionally or personally, but both professionally and personally. Each trait is contrasted to its opposite, or negative thinking style. As we review these traits, think about your own thinking and how you interact with patients and colleagues. How many of these traits do you routinely use? What have been the consequences or outcomes when you have used the positive traits? What have been the consequences of using the negative traits? Let's give consideration to these traits.

Intellectual Humility (versus Intellectual Arrogance): Having an awareness of the limits of one's knowledge or knowing what you don't know is intellectual humility. This section of the module began with quote attributed to Confucius. Reread this quote, it addresses intellectual humility in these words "to say you do not know when you do not." Or as Clint Eastwood, portraying Dirty Harry would say, "A man's got to know his limitations." Intellectual humility also means having an awareness of how one's own biases, prejudices, cultural influences, or limitations of one's viewpoints may be influencing one's thinking. Intellectual humility means we should not claim to know more than we actually do. Intellectual humility does not mean being submissive or imply spinelessness.

However for the critical thinker using intellectual humility, they know when they need more information or when to consult the expertise of others. Perhaps it has been years since you have taken care of a patient with a central venous line. You would know to consult another nurse or ask your charge nurse to review central venous lines with you and perhaps accompany you when you did the dressing change for the first time. *Intellectual arrogance* on the other hand is being pretentious, boastful, and conceited in our thoughts and presentation of our thoughts to others. A nurse hired by a staffing agency stated she was experienced with continuous tube feedings. However when assigned to a patient at a nursing home who was receiving continuous tube feedings, the nurse left the feeding in a free flow mode with the head of the bed flat. This patient subsequently aspirated and died. Was this nurse intellectually arrogant by saying she was experienced when in reality she wasn't? The inability to set aside our own personal biases and prejudices is also a sign of intellectual arrogance. For example you have been assigned to care for a convicted rapist who has been admitted to your unit. While caring for this patient, you make numerous comments to him that he is despicable.

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You do not bathe the patient or administer pain medication as frequently as you could because of your distaste for this person. This is an extreme example, but consider more subtle forms of arrogance, i.e., responses to an elderly patient, an overweight patient, or perhaps a patient with a mental illness. We have all seen practitioners with biases and have seen it affect patient care. What are your biases? What about cultural differences that may be portrayed as intellectual arrogance? Intellectual arrogance may also demonstrate a lack of logic or knowledge. A classic example of intellectual arrogance is when a question is answered with "Because this is the way we've always done it" kind of response. Perhaps the person you asked doesn't know the answer and rather than admit it, she takes a very arrogant approach to you.

Intellectual Courage (versus Intellectual Cowardice): Intellectual courage involves recognizing the need to face and fairly address ideas, beliefs, with which we may have strong negative emotions, and/or those items we have chosen not to give serious consideration. A person demonstrating intellectual courage may say, "I'm thinking outside the box here." Critical thinkers are always open to consider new ideas or methods. Intellectual courage is recognizing that ideas ingrained in us, perhaps culturally or via our system of beliefs, may be false or misleading. It is the realization that there may be some truth in ideas we considered absurd or perhaps even dangerous. An example might be, believing that there is absolutely no value in alternative treatments for patient problems, in spite of the fact a number of patients tell you acupuncture has relieved symptoms, created a remission of disease, and improved quality of life. Refusing to consider alternative therapies in light of published studies is intellectual cowardice. Blindly accepting what we have been taught, without thought, is *intellectual cowardice*. It takes courage to be true to our own thinking, i.e., "Maybe there is something to alternative treatments after all," especially when there may be penalties for nonconformity. For example, everyone with whom you work looks down their noses at alternative therapies and may ostracize you for giving such "voodoo" treatments any consideration.

Intellectual Empathy (versus Intellectual Narrow-mindedness): Intellectual empathy entails the ability to put yourself in the place of others in order to genuinely understand them. It is the ability to put yourself in their place. Put yourself in place of a patient who has just been told they have a very grave prognosis. What questions would you have if you were that patient? What would you find comforting? Intellectual empathy is not total emotional involvement, but it involves an awareness and appreciation for the situation, while maintaining the ability to remain objective. Intellectual empathy requires the ability to reconstruct accurately the viewpoints of others. Sometimes we say something like "I can see where you're coming from" to express our intellectual empathy. Intellectual empathy correlates with those times we are able to recall when we were wrong, despite our intense conviction we were correct, and thinking we could possibly be incorrect again in regard to the case at hand.

Think about a patient, you were sure X was the problem, only to discover it was really Y. Remembering this experience as you are thinking about your current patient keeps you thinking that there may be more or other problems you have not fully appreciated. *Intellectual narrow-mindedness* is illustrated by the nurse who says "Whenever patients grimace, they are in pain and I medicate them, because that's what I learned in school." Or thinking about the patient who has just received the grave prognosis, the intellectually narrow-minded nurse says "Well we all have our troubles don't we?" or "I would make my funeral plans and get my affairs in order now." Both statements lack empathy and are probably the last thing this patient needed to hear.

Intellectual Autonomy (versus Intellectual Conformity): Intellectual autonomy means having rational control of your own beliefs and values. Intellectual autonomy is "learning to think for yourself." Intellectual autonomy means we question when we think it is rational to question, believe when we think it is rational to believe and conform when we think it is rational to conform. For example, as nurses we know sterile procedures and we conform to those procedures in order to minimize risk to the patient. This is rational conformity. Intellectual conformity is when we blindly follow what we have been taught without thought. When asked why a procedure is done in a certain manner, the person demonstrating *intellectual conformity* may respond by saying "It's not important for you to know why, this is the way you are to do it, that is the way I learned it and it is the way it has always been done." What is missing in this example is rational thought; thus it is *intellectual conformity*. In many ways, intellectual conformity is a form of mindlessness that requires no active thought.

Intellectual Integrity (versus Intellectual Hypocrisy): Intellectual integrity involves the need to be true to one's own thinking. It means holding yourself, as well as your antagonists to the same intellectual standards and rigorous standards of evidence and proof. In other words, the person possessing intellectual integrity practices what they preach. For example if you expect others to admit they may have made a mistake, when they did make a mistake, you must be willing to make such an admission when you err. Intellectual integrity is having the ability to honestly admit discrepancies and inconsistencies in your own thinking and actions. Think about our patient Mrs. Jones, who had been complaining of pain. You've administered pain medications, but Mrs. Jones is still restless and anxious. You give report to the oncoming nurse, who points out that perhaps Mrs. Jones is having difficulty because she is also worried about her husband, who is home alone and has dementia. To this you state, "I hadn't considered this. Perhaps we can talk to Mrs. Jones and see if there is a neighbor or another family member who might check on the husband." The statement "I hadn't considered this" illustrates intellectual integrity in this case. A nurse demonstrating *intellectual hypocrisy* may have stated "If you want to delve into her home life, you can, but I have treated her pain."

Intellectual Perseverance (versus Intellectual Laziness): Intellectual perseverance is the ability to use intellectual insights, knowledge and truths in spite of obstacles, difficulties, and frustrations, and despite the irrational opposition of others. Situations that call for intellectual perseverance are frequently complex issues and may require a time allotment to resolve. Let's say you work with Mary, and you know Mary will react with a negative emotional outburst every time she is

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assigned to care for ventilator dependent patients. She has the knowledge base and competencies to work with ventilator dependent patients, she just chooses not to do so. Today Mary is going to be assigned to a ventilator dependent patient. How might you handle this? Perhaps if you point out Mary's competencies, experience and knowledge she will be more accepting of the assignment. Another tactic would be to remind her that every nurse in this particular unit takes a turn working with the ventilator patients, and it is now her turn. Another strategy would be to have a conversation with Mary about why she doesn't like caring for ventilator dependent patients and perhaps resolve the issue once and for all. These strategies demonstrate intellectual perseverance. With the trait of intellectual laziness, you would simply avoid Mary's emotional outburst all together, by not assigning her to the ventilator patient. Instead you would assign someone else who you know will accept the assignment, even though they were just assigned to the ventilated patient yesterday. *Intellectual laziness* often involves taking the easiest or quickest way out of a problem. Bear in mind, this may not always be the best solution to the problem and in fact may allow the problem to continue. In this case, if Mary is allowed to avoid caring for ventilator patients, what toll does that place on the remaining staff members who always have to pick up the slack left by Mary?

Confidence in Reason (versus Distrust of Reason and Evidence): Confidence in reason is believing that as you develop your own thinking skills, you can learn to think for yourself, form rational viewpoints, draw reasonable conclusions, think coherently and logically, and become a reasonable person. Confidence in reason also means giving latitude to others to develop their own thinking skills, so that they can learn to think for themselves. It also means allowing individuals to come to their own conclusions versus always giving them the answer. Let's consider the newly diagnosed diabetic patient who is now learning to administer insulin. You've taken him through the steps, he watched a video, you've demonstrated on a mannequin, he has demonstrated on the mannequin as well. Now it's time to actually administer his first injection.

In demonstrating confidence in reason, you will allow the patient to tell you what he is doing as he completes each step, with you stopping him only if he is about to do something incorrectly. When you do stop him, you simply ask him "What step comes next?" or you say "Do you really want to do that next?" but you allow him to come to his own conclusions and self-correct his actions. You also comment and encourage him when he has completed a step of the procedure correctly. This illustrates confidence in reason versus *distrust of reason*. If you were a person whose thinking trait was distrust of reason, you would remove the syringe and insulin from the hands of this patient while saying "let me do it" and proceed to administer the insulin. In other words, you were not allowing this patient time and experience to cultivate his own confidence in reason. When you distrust reason, you usurp the other individual's work towards thinking for himself. Another illustration of distrust of reason is the person who always has to do things their way. They don't trust anyone else to undertake the task "correctly"-meaning it was not done "their way." So rather than delegate or allow others to help, individuals employing distrust of reason will shoulder all the work and often become martyr-like. They will often make comments about all the work they have to do and how busy they are. In some cases they will forego breaks and lunch because they have "so much to do."

Fair-mindedness (versus Intellectual Unfairness): Fair-mindedness is the trait that treats all viewpoints alike without reference to one's own feelings or the vested interests of one's friends. Let's say you are caring for a patient who has become short of breath. You've suctioned her and made sure her oxygen is in place, but she is still experiencing some dyspnea. A respiratory technician enters the room and suggests you elevate the head of the patient's bed. If you are fair-minded, you will put the head of the bed up and thank the respiratory technician for his suggestion. If however you are applying *intellectual unfairness,* you respond by saying, "This is a nursing issue and I am the nurse, you are not. I will do what I think is necessary for this patient." In this example of intellectual unfairness, you totally discounted the viewpoint of the respiratory technician because he was a respiratory technician, not part of your nursing group.

D. Cognitive Skills of Critical Thinking. Besides possessing and utilizing the positive traits of critical thinking, nurses need to develop cognitive skills. There are many aspects to critical thinking and there can be an overlap of ideas about critical thinking. But here are some of the cognitive skills needed for developing a Nursing IQ.

Divergent Thinking: Divergent thinking is the ability to analyze many opinions, pieces of information, ideas and judgments and come to reasonable conclusions. Nurses do this every day in assessing patients, taking into consideration laboratory reports, diagnostic test results, clinical observations and the input of other healthcare team members. Not only do nurses do this during the admission process, but on an ongoing basis. Not all of the information nurses receive is always pertinent. With divergent thinking, the nurse is able to distinguish relevant from irrelevant information. Divergent thinking develops with practice and experience. Think about the first myocardial infarct patient or any other now routine patient diagnosis you encounter in your practice. How divergent was your thinking with your first patient versus the one you cared for today? Why is your thinking (hopefully) better today? It is probably because of all the knowledge and experience you have gained over the years. Those of you who are new or returning to nursing after an absence, take heart. With time and experience, you will develop the skill of divergent thinking.

Reasoning: Reasoning has to do with applying logic. It is the ability to distinguish fact from fiction and come to a logical conclusion. There are two types of reasoning: inductive and deductive. *Inductive reasoning* goes from the particular to the general. For example there is a patient who experiences hypotension after receiving a dose of morphine sulfate via IV push. A nurse using inductive reasoning might conclude that any patient receiving morphine sulfate via IV push might experience hypotension. Thus with future patients this nurse will cautiously administer the medication and monitor blood pressures when giving morphine sulfate via IV push. *Deductive reasoning* goes from the general to the particular. For example, it is well known that any patient with an indwelling urinary catheter is at an increased risk for infection. Therefore the patient who just returned to your unit from hip replacement surgery with an indwelling catheter is also at increased risk for infection.

Reflection: Reflective thinking is the ability to think back on or recall past experiences, glean valuable information and apply that information to the situation at hand. How many times after

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the end of a shift, have you reflected and thought about what you learned from that experience? How many times have you reflected on what you saw another nurse do and learned from that situation? How many times have you thought you would do things differently the next time you encountered a similar situation? When faced with a situation, how many times have you been able to recall a previous patient or experience and integrate that into the current situation?

Have you ever responded instinctively to a situation? Have you ever positioned the crash cart just outside of the patient's room, just "because," or just because "they didn't look right"? Without realizing it you are most likely reflecting on other patient experiences where patients did end up "coding." Many people may refer to this as intuitive thinking, but I like to think of it as critical thinking in action, or having a Nursing IQ. I personally believe reflection is one of our most important critical thinking skills. It allows us to actively learn from our experiences. Nurses who do not reflect may have years of experience, but they have not learned from those experiences and may actually be functioning at a beginner level. It's not the experiences that make the nurse; it is what the nurse makes of the experiences.

Creativity: Let's face it, nursing calls, *begs* for creativity and critical thinkers are usually very creative thinkers. Thus to use some deductive reasoning (going from the general to the specific), nurses, being critical thinkers, are creative thinkers! How many different nursing interventions can you list for alleviating pain? How many nursing interventions can you identify for preventing and treating pressure ulcers? (In nursing school, I think we all wrote at least a 30 page nursing care plan regarding pressure ulcers!) How many different strategies have you employed to get a patient recovering from open-heart surgery to turn, cough and deep breath? Have you ever been astonished by and admired the creativity of a colleague? Have you thought to yourself, wow, I wouldn't have thought of that great idea! Creativity gives us the ability to problem-solve. It also gives us options. If plan A doesn't work, we'll switch to plan B, plan C, etc.

Clarification: Nurses constantly clarify. We clarify physician orders so we clearly understand their intent. We clarify often ambiguous information from patients by asking more questions. We clarify information and terminology for patients and their families so they have a better understanding of us. Clarification is not assumption. The nurse who assumes what a physician meant in that handwritten order may be about to create a huge error! A rule to follow is when in doubt, be sure to clarify-that is critical thinking. Assuming information not in evidence or applying your own interpretation is not clarification or critical thinking.

III. Characteristics that Prevent Critical Thinking.

We spent some time on the characteristics, intellectual standards, traits and skills of critical thinkers, now we will turn our attention to some traits that get in the way of critical thinking. Knowing what not to do is as equally important as knowing what to do. Remember (reflect back upon) the traits of critical thinkers. In that section we contrasted the positive intellectual trait with its negative trait. We will not repeat them here, but remember that these negative traits will prevent or hinder critical thinking.

I also like to refer to this section as *"What were they thinking?"* We have a tremendous number of very intelligent, skilled professionals working in healthcare. But why is it that a very intelligent person can make such grave errors as evidenced in the Institute of Medicine 1999 study previously referenced. Yes, many errors are created by system problems, i.e., not having or conducting a preoperative checklist or allowing interruptions from co-workers when administering medications. But there are also errors due to the fact that someone was not thinking or has fallen victim to a fallacy in their thinking.

Robert J. Sternberg theorizes that it actually takes a very intelligent person to make a really stupid mistake! Think about these examples. How did Richard Nixon become involved in Watergate and the subsequent cover up? Did the executives at Enron really think they could get away with the shell game they were running and not create a disastrous outcome? Or for a more recent example, do bankers and mortgage companies really think it is wise to sell a $1 million home to someone barely making minimum wage? Why do these same bankers and mortgage companies think it is perfectly acceptable to extravagantly redecorate their offices and expect bonuses when their companies are being kept viable with taxpayer money? Now for the really scary question: Have you encountered this kind of thinking in healthcare? When you have encountered this type of thinking, what have been the outcomes? For the patient? For staff morale? What was the outcome within the community?

Unfortunately we are not always aware of when we are being stupid. It often takes someone else pointing it out that we become aware or when we reflect back (see what a valuable critical thinking skill this is?) and realize we've made an error. We often are amazed we could have been so oblivious to our own stupidity. How many times have you said to yourself "How could I have been so stupid?" or "That was a really dumb thing to do!" If so, you just realized you made an error and now have the opportunity to self-correct. However what about the person who doesn't see the error of their thinking or the error of their ways? They do not correct behaviors and continue to fall victim to their own fallacies and unfortunately may perpetuate horrendous outcomes. Now let's look at some fallacies of thinking that can cause smart people to do stupid things-in other words not think critically!

A. Egocentrism Fallacy: Because we believe we are smart, we believe the world does or should revolve around us. *Egocentric thinking* occurs when we do not consider the rights, needs and viewpoints of others. We only take into consideration what we are thinking or our viewpoints. After all, if we are smart, we must know everything! Think about two-year-olds, they can be extremely egocentric in their thinking. They want what they want and they want it now, or they have a temper tantrum. They want to climb up on to the stove. They want to cross the street because they know how even if they don't stop and look both ways! The world revolves around them.

However, with nurturing parents, they are taught the virtues of patience, sharing, politeness, safety, and delayed gratification, thus learning to become aware of their own egocentric thinking. In other words, we learn the world does not revolve around us. Individuals who do not learn to consider the viewpoints of others or recognize the limitations of their own thinking develop an egocentric style of thinking. Egocentric thinkers think they actually have it all figured out, they believe they have done this objectively and they believe in their own intuitive perceptions-even if they are inaccurate.

Egocentric thinkers use and rely on *psychological standards* for thinking versus critical thinking standards. Some common psychological standards are:

- **It's true because I believe it.** The individual makes an assumption that what he believes is true because he has never questioned the basis for that belief. In first grade I was taught all robins fly south for the winter. I believed it to be true; after all they taught us little 6 year olds this fact of nature. Imagine my surprise when I spotted a flock of robins that stayed in my yard all winter! Upon talking to the conservation officer, he told me as long as there is water and a food source, some robins will choose not to migrate south! So ideas we hold

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to be true, even for long periods of time, may be proven to be inaccurate!

- **It's true because we believe it.** The individual assumes that the beliefs held within a group are true, even though she has never questioned the factual basis. In nursing school we were taught to treat pressure ulcers by painting them with a mixture of hydrogen peroxide, Cepacol™ mouthwash and Milk of Magnesia. Then we would apply a light to the ulcer-literally baking the concoction on to the wound. We did this without question because our particular nursing instructor told us not to question, as this was *the way* to treat a bedsore! So we dutifully painted one ulcer after another and baked them to a nice crust. Why? Because we believed it to be the best treatment, because the group to which we belonged believed it was the best. Fortunately, we now know better. It does give one pause though. What do we believe today that will be proven ineffective tomorrow? What about beliefs with groups? What do some physicians believe about treating pain, because of the influence their group has on their beliefs? What do some nurses believe? What do some clergy believe about treating pain? How does a group influence us? This is why we need critical thinkers!

- **It's true because I want to believe it.** When the belief puts the person in a positive versus negative light, the individual assumes the belief to be true. The individual believes in those things that make him "feel good," but does not require him to necessarily change his way of thinking or cause a change in behaviors.

  For example, Joe, a middle manager, is very vocal about recycling used equipment and spent office supplies while at work. He receives many accolades from his boss for "being green" and this makes Joe feel good. However, at home he recycles nothing. So recycling at work puts Joe in a positive light, the accolades make him "feel good" and he believes it is the right thing to do at work, but he clearly has not transferred that same style of thinking or actions to his home environment.

- **It's true because I have always believed it.** This appeals to the need for self-validation. We want to know that what we know is true, and because we have always known it, it must be true. Think back to the pressure ulcer example we discussed. What if we had practitioners who refused to change their practice because of what they have always known? How many bedsores would we still be treating in an archaic manner? Even in the face of evidence based practice, we still have healthcare practitioners who are reluctant to change simply because they hold this belief.

- **It's true because it is in my selfish interest to believe it.** This psychological standard appeals to one's innate sense of selfishness. In an effort to procure power, money, or personal advantage, an individual holds onto beliefs, even though these beliefs are not grounded in sound reasoning. Reflect on what is happening with current mortgage problems. There have been accusations of predatory lending, where mortgage companies have persuaded a home owner/buyer that they could afford that huge home on a small salary. After all, what does the mortgage salesman care if the individual defaults on their payments? The salesman has made a sale, met his quota for the month and gets his monthly bonus. Further the mortgage company will bundle this mortgage with others and sell them to another mortgage company anyway, so it won't even be his company's problem. This psychological standard offers insight into many problems that have occurred, such as Watergate, Enron and the current banking and mortgage woes facing our country today. Have you seen evidence of this in healthcare? What about the nurse who always leaves things undone, just so she can get off duty on time? The next shift has to pick up the slack. What about the person who volunteers for projects in an effort to gain a personal advantage, then delegates the work to others?

B. Omniscience Fallacy: We believe that part of the reason the world revolves around us is that we know so much more than we actually do. As a person becomes more imbedded in egocentric thinking, he or she may adopt omniscience. By virtue of the title we hold or our status in life, we continue to be enamored with ourselves. Perhaps the person believes, 'I am a registered nurse, I know everything about nursing'. Or because I have a Ph.D. in bubble gum chewing, I am the world's leading authority on bubble gum. The world looks to me to have all the answers about nursing or bubble gum, and I believe I do have all the answers. Have you encountered these individuals in healthcare? How did omniscience influence patient care? This is a true example. A registered nurse, working on a medical-surgical unit, undertook to intubate a patient one night because he had "seen it done" previously and now thought he was eligible to do so.

C. Omnipotence Fallacy: We believe because we know so much, this knowledge makes us omnipotent. We can do whatever we want and get away with it. No one will question our knowledge. This is taking egocentric thinking a step further, from omniscience to omnipotence. A nurse friend of mine works in an OR. She has witnessed a particular surgeon throwing surgical instruments when anyone speaks to him or asks questions. In some instances he has broken equipment during his tirades, yet no one questions him or confronts him because of his title. He is so arrogant in his behaviors, he feels it entitles him to throw equipment, and be allowed to get away with it. The sad thing is that is exactly what is happening. No one confronts this surgeon; therefore the behaviors continue, feeding into his feeling of omnipotence ever more.

Another unfortunately true example of omnipotent thinking involves another physician. However this situation was handled differently. This particular surgeon has two patients in the same room on a surgical unit. The physician, without being accompanied by a nurse, examines the first patient, removes the surgical dressing and leaves the wound open for the nurse to redress. Then he proceeds to wipe his hands on the curtain separating the two beds and approaches the second patient. Fortunately the second patient, seeing him use the curtain to clean his hands, tells the physician he is not going to touch her. He laughs and say it's OK, he does this all the time. Again the patient advocates for herself and refuses to allow the surgeon to touch her. He replies he will have the nurse change her dressing and leaves the room. Later, when the nurse enters the room the second patient tells the nurse of this incident. The nurse informs her nurse manager and infection control officer, who in turn deal with this physician. The infection control officer uses data of infection rates for this surgeon to confront him with not only the observations of the patient, but with the hard evidence that he has the highest post operative infection rate. It is made very clear to this physician by both the infection control officer and the hospital CEO; this behavior will not be tolerated. His admitting privileges are suspended for three months and when he returns his infection rates will continue to be scrutinized. Clearly here is a person who believes he was omnipotent and could get away with anything. Fortunately the second patient was able to advocate for herself and ultimately this put an end to this behavior on the part of the physician. The frightening thing is, how many times had he done this previously? How many patients experienced unnecessary postoperative infections because of his omnipotence? How many patients would not have advocated for himself or herself like this patient did? Can you think of other examples of omnipotent thinking you have witnessed? Have you witnessed nurses being omnipotent? What has been the outcome of such thinking?

D. Invulnerability Fallacy: We believe, because we are omnipotent in our knowledge, it makes us invulnerable to attack, question or criticism. Taking egocentric thinking yet another step further, brings us to the invulnerability fallacy. Let's continue with the example of the surgeon who throws equipment in the OR. Adding to this situation is the fact that this surgeon is the only pediatric ophthalmologist practicing at this hospital. Thus everyone defers to him. Because there are no other pediatric ophthalmologists, there is no one to question or criticize this surgeon. Thus in order to have his services available to patients, and bring money into the hospital, no one questions or confronts his behaviors. He now feels he is invulnerable and at times his tirades escalate, simply because he knows he can get away with it.

E. The Halo Effect: The Halo Effect occurs when we mentally paint a halo around an individual, vesting in him or her capabilities that perhaps s/he does not possess. This is not egocentric thinking, it is us bestowing an aura of infallibility on a person we hold in esteem, respect and may be beloved to us. The problem here is that because we hold this person in such high esteem, we don't think they are capable of making mistakes. Thus we may not even recognize when they do make a mistake. Or because of the halo we have bestowed upon them, we don't question when we do see an error, because after all, it is our sainted person who is making the error. This can't be, surely they must be correct! This can be a common occurrence when less experienced professionals work with those who have more experience. The beginner nurse watching and learning to insert a foley catheter sees the more experienced nurse break the sterile field and contaminates the catheter. The experienced nurse proceeds and inserts the catheter. However, even though the beginner knows this is wrong, she doesn't speak up, because after all, this more experienced nurse has put in many more foley catheters than she has. The beginner nurse is now thinking things like: "Certainly the more experienced nurse knows what she is doing. Who am I (the beginner) to question someone with so much experience and know how? Maybe I just thought she contaminated the catheter. Surely if she had contaminated the catheter, she would obtain a new one, not proceed to use the contaminated one. Maybe I just thought I saw her contaminate the catheter." Eventually the beginner actually talks herself into believing she is the one who is wrong! Even when the patient develops a urinary tract infection, the beginner nurse does not equate it with the possible contaminated catheter.

The Halo Effect is a particularly dangerous mode of thinking because it perpetuates and

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exacerbates mistakes. Often in healthcare we experience a culture where we have bestowed sainthood on esteemed, knowledgeable and talented individuals that holds them to a standard of perfection. And while they *are* remarkably talented and knowledgeable, no one can maintain a level of perfection. The Halo culture says these individuals are *always* right and we extend extreme deference to them. To further complicate this mode of thinking is that part of the Halo Effect and our culture is to *discount less experienced individuals*. Anyone who has worked in a teaching facility has witnessed the pecking order of attending physician to chief resident to resident to intern. Sometimes the intern is correct, but everyone defers to the more senior physician. What has been the pecking order of nurses you have witnessed? Think back to your first job. How were you treated if you made a suggestion during change of shift report? Have you ever heard that you have to "prove yourself" in order to gain respect? In other words, you had to earn your halo.

How many of you had a similar experience to this? As a new graduate nurse Helen's first job was in neuro ICU. This was during the nursing shortage of the late 1970's to early 1980's. The hospital was desperate for help; thus some new grads were hired directly into the ICU's. Routinely and if beds were available, patients undergoing carotid endarterectomy would be admitted to the ICU preoperatively for placement of Swan-Ganz catheters and CVP lines. This way baseline parameters could be obtained on the patient to use postoperatively. Helen had cared for Mr. Denby preoperatively and now he was back in the unit postoperatively. Preoperatively Mr. Denby was a very quiet, intelligent, prim and proper gentleman.

However postoperatively, Helen found him to be confused. He was attempting to climb over the bedrails, exposing his bare bottom to everyone in the unit. He was biting his IV tubing and pulling on his Swan-Ganz catheter. In addition to all of this, Helen noticed his left grasp was weaker than his right grasp, yet he was oriented to person, place and time. He could even tell Helen he had undergone carotid endarterectomy surgery that day. He was also going in and out of atrial fibrillation, with a controlled ventricular rate, when normally he had been in a normal sinus rhythm. Helen reported all of this to the intern on call. The intern arrived in the unit, examined Mr. Denby and told Helen it was "just ICU psychosis." Helen persisted with the intern, describing Mr. Denby preoperatively versus his current behaviors. Helen again pointed out the difference in his grasps, which she told him had been equal preoperatively and about the change in heart rhythm. He continued to discount her observations and concerns, told her to "keep an eye on him," and left the unit. Helen consulted with another colleague, who confirmed her findings and validated her concerns. Mr. Denby continued attempting to climb out of bed; his grasps continued to be unequal, yet he remained oriented to three spheres. Helen again paged the intern. He again came to the unit. Helen again persisted with the intern to which he responded he would hate to have to call the resident on call and "bother him." Helen persisted and he paged the resident on call. When the resident arrived, she shared her observations and concerns. The resident never said anything directly to Helen, but he did order an electrocardiogram and blood work. As it turned out, Mr. Denby was experiencing a myocardial infarction as well as showering embolisms from the heart and endarterectomy site up to his brain and he was having strokes. While Mr. Denby suffered complications from his surgery, he did eventually recover after an extended period of time on the rehabilitation unit.

How many of you have experienced something similar? Because you were new to a facility or a beginner, your professional observations were disregarded, simply because you hadn't earned your halo yet? You couldn't possibly know what you were talking about. Or how dare you bother the resident-or worse yet, the attending! Another interesting facet of this case study is that those who were wearing halos, i.e., the intern and the resident, who were always expected to be correct, were not. Neither of them said anything to Helen like "good going" or "good pick up," because that would have meant they would have to acknowledge they had missed something or made an error. Do you see the double-edged problem the Halo Effect causes? Thinking back on this incident, Helen doesn't find herself being angry, she just thinks they were all victims of the Halo Effect and the culture it had created. However had Helen not had confidence in her reasoning and perseverance, things could have had a horrible outcome for Mr. Denby. Unfortunately the Halo Effect is still alive today in many healthcare settings.

Perhaps about now you are thinking to yourself "How am I supposed to be thinking?" We've covered a lot of ground in metacognition, or thinking about our thinking. I'm sure you've recognized yourself, as well as colleagues and co-workers in some of the examples that were given. We are all human, and can easily fall prey to making mistakes. Perhaps colleagues continuously tell us how smart we are and they always seek us out for advice, leading us into egocentric thinking and the Halo Effect. Be aware of these pitfalls. Pitfalls can and will happen to us-all of us, even the best of us. What is important is that we continuously learn and think about our thinking. It is my hope with this module, that I have been able to create awareness about our metacognition. Review this module. Re-read it. Discuss this module with a colleague. Become familiar with the critical thinking traits, both positive and negative, and critical thinking skills. Use reflection to identify instances when you used a positive trait so that you can continue using that trait. Recognize when you fell into a negative trait or egocentric mode of thinking so you can rethink the situation and self-correct. Use case studies from your own place of work to analyze the thinking styles evidenced. In subsequent modules in this series, we will be delving deeper into critical thinking.

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Independent Study Post Test continued on page 14

Characteristics of Critical Thinking: What Critical Thinkers Do What Critical Thinkers Do Not Do

Post Test and Evaluation

Name:_____

Date:_____ **Final Score:**_____

DIRECTIONS: Please complete the post-test and evaluation form. There is only one answer per questions. The evaluation questions must be completed and returned with the post-test to receive a certificate.

Please circle one answer.

1. To be aware of one's thinking is a form of critical thinking.
   A. True
   B. False

2. Mindfulness means to be mentally engaged.
   A. True
   B. False

3. An element of critical thinking is that it is self-directed.
   A. True
   B. False

4. Mindlessness occurs when we do not pay attention to what we are doing.
   A. True
   B. False

5. Mindlessness does not result in errors.
   A. True
   B. False

6. Clarity is the gateway to critical thinking.
   A. True
   B. False

7. Information may be clear, but not necessarily accurate.
   A. True
   B. False

8. Precision involves obtaining specific information or details.
   A. True
   B. False

9. Relevance does not play a role in nursing decision-making.
   A. True
   B. False

10. Depth has to do with the complexity of the issue or problems at hand.
    A. True
    B. False

11. A variety of points of view add breadth to an issue.
    A. True
    B. False

12. Logic is when we bring together a variety of thoughts into some order.
    A. True
    B. False

13. Trivial information is essential to critical thinking.
    A. True
    B. False

14. Intellectual humility is knowing what you don't know.
    A. True
    B. False

15. Subtle biases or cultural differences may elicit themselves as intellectual arrogance.
    A. True
    B. False

16. Intellectual courage is realizing long held beliefs may be false, while ideas we considered absurd may be true.
    A. True
    B. False

17. Putting yourself in someone's place to genuinely understand him or her is intellectual empathy.
    A. True
    B. False

18. Intellectual integrity is the willingness to admit to mistakes and discrepancies in one's own thinking.
    A. True
    B. False

19. When one discounts the viewpoints of others it reflects the use of intellectual fair-mindedness.
    A. True
    B. False

20. Divergent thinking and reasoning are cognitive skills useful in nursing.
    A. True
    B. False

21. Reflection is the skill of integrating past experiences into current situations.
    A. True
    B. False

22. Applying your own interpretation to information is considered to be clarification.
    A. True
    B. False

23. Reflection also gives us an opportunity to realize errors and self-correct.
    A. True
    B. False

24. Egocentric thinking is when we give consideration to the viewpoints of others.
    A. True
    B. False

25. Egocentric thinkers rely on psychological standards versus intellectual standards to guide their thinking.
    A. True
    B. False

26. Omniscience has to do with a sense of knowing more than one actually does.
    A. True
    B. False

27. Omnipotence is believing one can get away with behaviors or actions because he or she is so intelligent.
    A. True
    B. False

28. We might not see an error because we do not expect the person we hold in esteem to make an error.
    A. True
    B. False

29. A Halo culture places a standard of perfection on knowledgeable individuals and at the same time discounts the knowledge of less experienced individuals.
    A. True
    B. False

30. We are all subject to egocentrism and it is important to continue our efforts of metacognition.
    A. True
    B. False

Evaluation

	Yes	No
1. Were you able to achieve the following objective?		
a. Define critical thinking.	☐	☐
b. Identify universal intellectual standards and cognitive skills as they apply to critical thinking.	☐	☐
c. Contrast positive versus negative essential intellectual traits.	☐	☐
d. Recognize characteristics that prevent or hinder critical thinking.	☐	☐
2. Was this independent study an effective method of learning?	☐	☐

If no, please comment:

3. How long did it take you to complete the study, the post-test, and the evaluation form?

4. What other topics would you like to see addressed in an independent study?

Registration Form

Name:_____
(Please print clearly)

Address: _____
Street

_____
City/State/Zip

Daytime phone number: _____

_____ RN _____ LPN

Email address:_____

Please return:
– Completed Post-test and Evaluation Form
– Registration Form

TO: Ohio Nurses Association
4000 East Main Street
Columbus, OH 43213

A (Student) Nurse Leader State of Mind

Rebecca Denoncour
Indiana Association of Nurse Students
Newsletter Editor
University of Southern Indiana Nursing Student

Go ahead; ask my critical care instructor how many students volunteered to be team leaders for our upcoming ACLS simulation. I can tell you, the tally falls short of the number needed; and, in full disclosure, you won't find my name on that list. I suppose that must mean I – not to mention a host of my nursing classmates – am not much of a student leader. After all, from the time we are in preschool, we are taught leaders are the people at the head of the line, directing the path of their peers. Leaders are the students who sit in the front row, answer the teachers' questions. They are responsible and they take on additional responsibilities, like getting involved in student nursing organizations. Looking ahead, they are the nurses who take on charge duties, serve on committees, devote extra time to evidence-based practice and process improvement projects. Nursing leaders – and their student protégés – take charge, speak up, and willingly step out, front and center, to serve as the exemplars and guide their profession.

But true leadership is much more than cultivating professionalism and directing progress.

To really be a nurse leader, you first have to have a strong foundation in and a passion for the nursing care you provide. It is easy to sign up for a leadership role, to undertake an officer position on a student nursing board, pay your dues for honor society membership. However, it is far harder to cultivate the knowledge, develop the confidence and foresight required to translate the ideals and goals of an organization or profession into practice and encourage the same in others. And day-to-day, it is often far more compelling to lead by dedicated example and commitment to the work you do than by virtue of the positions you hold and advancements you make for your field. Of course, being passionate about the care you provide, taking pride in its importance in helping patients and families to heal and recover goes a long way in motivating continual growth and improvement in individual nurses and of the nursing profession as well.

True leadership, additionally, involves more than distinguishing oneself from one's peers. Fortunately for those of us training to become or working as nurses, unlike other disciplines, 'leaders' and 'leadership' in nursing are not unequivocal, fixed concepts. We encouragingly remind each other in nursing we never work alone. Quite the opposite, we rely on teamwork amongst ourselves and with other healthcare professions, a dynamic that necessitates leadership roles fluidly shift according to patient need, individual strengths, and collaborative efforts. Sure, as in the case of the code simulation, sometimes the situation demands an individual set himself or herself apart and quite literally lead the scenario. But even so, and, routinely in nursing, different individuals exhibit leadership qualities at varying times and in many ways. The code team leader calls the shots, but the fellow nurse who advocates for the patient by questioning an incorrect medication dosage also demonstrates leadership through assertive and potentially life-saving actions. Again, leadership in nursing is more than a role or condition of distinguishing oneself; it is a habitual state of mind.

Okay, yes, student nurse leadership still also strongly encompasses participating in professional organizations and learning what it means to be a nursing professional. It entails developing the knowledge, skills, and attitudes to not only practice, but to improve the science of nursing. Which is why, yes, you really should still encourage your students, student-nurse employees, co-workers, or student peers to participate in the Association of Nursing Students at the campus, state, and/or national level. It is also a leading reason to mark your calendars for January 24, 2015 and the Indiana Association of Nursing Students' Annual Convention, "Opportunities on the Horizon," to support the current generation of nursing students in beginning their development of a professional, dedicated, and informed nursing practice. Most importantly, however, becoming a nurse leader entails being a student leader who adopts a state of mind that values a combination of personal and professional growth, teamwork, and taking the lead in big ways and small.

Holiday Greetings from the Board and Staff of the Indiana State Nurses Foundation and Association