

# PONT DU GARD FORUM

## “Let’s Get Real”

### Choosing Silence Choosing Voice

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#### The Healing Waters of Pont du Gard

There is an architectural wonder in the south of France called the Pont du Gard. This structure completed in 19 BC consists of arches that support and channel water over many miles to the city of Nimes. The structure has provided for communities of people who required and shared refreshment and nourishment from the flowing water. Like the life-giving water, the vision for the initiative described here is to create a channel of dialogue, understanding, change, and growth. A dialogue that offers nourishment for nurses, just like the Pont du Gard offered nourishment for thousands of people in the south of France.

The Pont du Gard inspired nurse leaders from two large university centers to think about the possibility of creating a place where nurses could gather to explore and discuss the tough issues and hard questions about nursing and the workplace. A place where nurses might feel free to question and to seek answers about things they always wanted to ask but were afraid to voice—things about ourselves, our work, our colleagues, our leaders, our intentions, our failures, our shames, our hopes, and our fears. A place where truths are invited and respected. A place for nurses to consider the meaning of community among nurses who believe in compassion and knowledge. A place for nurses to ponder and discuss questions such as: How can nurses stand tall and cherish the reality that they make an incredible difference to the client’s quality of life? How do organizations support and honour the work of nurses and their intent to care for persons and families? How do nursing leaders enhance the voice of front line staff nurses? What silences nurses? And, how can nurses and nurse leaders stay true to their values?

This column presents a dialogue among nurse leaders and others who participated in discussions about nursing and human care. The hope of the authors is to enhance understanding about the knowledge, processes, and structures that impact nursing worklife and that help and hinder nurses in their work to create compassionate relationships

that enhance health and quality of life. The dialogues represent opportunities to seek the truths that will help us understand the realities of nursing—in large organizations and perhaps beyond. We believe that understanding can lead to changes that may restore and enhance human care and compassionate relationships among all nurses who share in the life-enhancing dialogues presented in the columns.

**Mary:** Interesting how the discussion today quickly settled on the topic of silence and what nurses think about when choosing to speak up for patients or for themselves. It was also obvious, at least to those present to hear the stories, that nurses often choose to be silent. You have to wonder about the issue of silence in nursing. Some nurses described their silence in relation to the absent community, or more accurately, the absent caring and communing that nurses wished they had with their colleagues and leaders. The concept of community has once again surfaced in this discussion, but of interest is the way that community was seen as limiting opportunities for change. I think it is worth thinking about the notion that you need to be in community (with others) to know you are or are not being listened to.

**Gail:** Being listened to is what I was thinking about when I asked the question, Who needs to listen to nurses? Given that nurses are the ones closest to clients, who do nurses want to be heard by? It was quite unsettling to hear the nurses say that even when it comes to patient safety, a manager’s message to staff about wanting to hear them influences their decisions to speak, or not. The important message the nurses were giving us in this discussion was that managers are critical when it comes to the nurses’ willingness to speak about their concerns and questions—for patients or for themselves.

**Mary:** The connection to openness on the part of the nurse managers as a major influence rang true with both my research findings and experience over time. The nurses indicated that their willingness to speak up depends on whether or not they believe that the manager is open to listen. Again, it is interesting to think about how silence and speaking are created in community and how they shape the nature of relating, the giving and taking of messages for all members of a community.

**Gail:** And the issue of nurses being pressured by others to keep silent is one that I have witnessed and experienced in my career. Even though it is familiar, it is still unsettling to hear that nurses experience pressure and threat from their peers and even more alarming to hear that there are some managers who also bully and pressure nurses to be silent. The nurses’ observations that there are some nurses who speak up anyway raised more questions because nurses believed that the voice of one courageous nurse does not

and cannot represent the views of the silent minority. One voice does not equal many when it comes to nurses who are fearful of expressing their views. I wonder how managers encourage or discourage the many voices of nurses?

**Mary:** One nurse manager attending this forum expressed her belief that a culture shift is required in nursing and that the education of nurses needs to be at a more professional level to inculcate respect for the work of nurses. I was moved when she spoke of how nurses, in order to have a strong voice, need to bring their own self-respect to their practices. She spoke of the struggle within her family and her culture because they did not respect nursing as a career choice and how she was still able to pursue her dreams and to feel a sense of pride about being a nurse. Such a culture shift of respect and pride in one's work may take a long time to become the predominant view in nursing. Even though some nurses know that the practice of nursing requires nursing knowledge and that knowledge guides our relationships with clients, some still see nurses as handmaidens or physician extenders. Nursing's unique practice is still largely not understood or respected. I loved the suggestion that we call Doctors' Orders, Doctors Requests. I wonder what that change might mean to nurses and doctors?

**Gail:** It's interesting to think about nursing education. I agreed whole-heartedly with the suggestion that theoretical frameworks can help provide a guide for nurses so that they know what they are expected to talk about with clients and with colleagues. I was encouraged by the comment that a conceptual framework can help nurses have confidence and to feel that what they have to say about persons is important and should be of interest to others. Again, it was the manager who was noted to be of particular help creating practice expectations so that nurses choose to speak up and to offer their opinions, ideas, and suggestions. Otherwise, nothing will change.

**Mary:** We know that the behaviour of the Nurse Manager is crucial. Autocratic control holds the system down and does not facilitate a culture shift. I think that nurse leaders have to speak up and name the issues we want to confront. It is up to us to say that an autocratic style of nursing management just doesn't fit, and indeed is a danger to nurses and to patients. Yes, nurse managers are under a great deal of pressure, and budget pressures must be addressed, but that does not mean that autocratic control is justified or defensible. It is true that nurses require the courage to speak up and it is also true that some managers punish nurses who try to make change. It is understandable that nurses look to their gender as well as their education to try to understand what is behind our fears to speak freely in healthcare.

**Gail:** When I asked: What is not being said? I did not expect the answer about moral distress. The nurses described experiences that reminded me of Webster and Baylis's (2000) notion of moral residue. The nurses said that they are taking moral distress home with them. Nurses described the hesitancy of challenging a colleague's practice. One nurse said she needed time to think before confronting a situation where something happens between a nurse and patient that concerns her. Then the next day it may be harder still to speak about the distress. The story told by one nurse about walking toward another nurse wheeling a patient down the hall was quite telling. The nurse pushing the wheelchair and the older woman being pushed both silently mouthed the words "help me" as they proceeded past the approaching nurse, to the shower. There is almost a sense of shared meaning behind this scene of both nurse and patient looking to be rescued; but, from what?

**Mary:** At Baycrest, we did confidential interviews with all the nurses. This gave the quiet people an opportunity to speak and it was very interesting to hear about some of the things not being said on units to managers. Nurses talked about difficulties with colleague relationships, lack of support among peers, and things happening to patients that "they did not like to see." Some nurses work with intense moral distress, disrespect, and no sense of teamwork or collegiality. Is it any wonder there is a fear to speak one's thoughts?

**Gail:** Congeniality, respect, kindness, affection, generosity, beneficence, integrity, authenticity—all these things help nurses believe that it is safe to speak. Questions of gender, power, and birth order will continue to be explored as possible ways to explain how nurses relate with each other and their supervisors. Nurses clearly wanted to learn more about supporting each other and speaking in ways that foster true collegiality. A question posed to other nurses: What shall we do with anger, fear, and moral distress when we see it next in our nursing communities?

**Mary:** We have to find a way to get to the other side, to move from silence to voice. I began thinking about our collective silence as being connected to some of the more distress nurses were speaking about. I also thought that our voice resides in a sense of connection and engagement among us and the meaning of nursing. Our collective meaning is in turn connected to nurses' reasons for building relationships and caring for clients. One nurse took this a little further by saying, when we are in pain we focus inward. Our voice or lack of voice depends so much on how we feel about ourselves. We need to find ways to open and connect. When we encounter practices that are unethical or just cruel we can become paralysed by the pain of moral distress. The pain and distress of work often carries over into our whole perspective and understanding of nursing.

**Gail:** Yes, and I am sure we lose some nurses who choose to remain silent about the pain and moral distress they feel at work. Everyone agreed we need to keep talking and trying to disclose nurses' experiences. Our discussion of the value of continuing these discussion forums was a good way to wrap up the meeting. I was glad to hear from the nurses that they enjoyed the openness and the ability to hear the perspectives of others who care about nursing. The nurses believe open dialogue in a supportive setting enhances their common bond as nurses. They are inviting us to continue and are also excited about us bringing the forum to the University Health Network, Mary, where you will be working as a nursing leader. Our numbers are growing and important talk among nurses is happening!

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Your comments are appreciated. Please email the authors.

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