COMMENTARY

Regaining Our Professional Vision

Sally Thorne, RN, PhD, FAAN, FCAHS, FCAN
Professor
School of Nursing
University of British Columbia
Vancouver, BC

Abstract
With a global nursing workforce shortage upon us, governments and health system decision makers are becoming alarmed at the potential risk to service delivery if solutions are not found. However, nurses know that what constitutes the fundamental threat to a healthy healthcare system is not the hard work of nursing, but rather the demoralizing conditions under which many nurses strive to practise their profession. This commentary examines the context for some of those conditions and encourages a collective commitment to articulating our vision for the profession in a manner that is sufficiently forceful to be effective.

Introduction

The COVID-19 pandemic spanning 2020 to 2021 (and likely well beyond) has taught us much about the implications of allowing nursing to be treated as a workforce problem. Hopefully, it will become a catalyst for some deep and strategic consideration of how we have allowed ourselves to be perceived as the target of modern health system engineering efforts rather than the proud and widely respected profession that so many of us consider the reason behind the essence of the work we do.

Discussion

As I wrote this in late August 2021, I saw the world becoming increasingly alarmed about the impending global nursing shortage catalyzed by the conditions arising from the COVID-19 pandemic (ICN 2021; Silas and McKenna 2021). To be clear, it is not the exhaustingly difficult work of caring for large numbers of critically ill and dying patients that has nurses stepping away from the profession in utter collapse; it is the crushing conditions under which they have been asked to do that work, including the non-existence of meaningful respect from those who make fundamental decisions affecting that work. These demoralizing conditions include trends such as a managerialism ethos within health service

administrations, accountability mandates that rely on efficiency measures, a shifting skill mix toward downsizing the proportion of the nursing workforce that has higher levels of education, over-regulation and standardization of clinical practices, the mandate toward interprofessional teams and leadership structures and the increasing use of the forms of electronic surveillance and record-keeping systems that perniciously control the everyday work of nurses (Molina-Mula et al. 2018). As our healthcare organizations have increasingly become corporatized over the past two decades, they reflect a clear preference for "operations" oversight and systems of exerting authority over the more internalized professional development and self-regulation that was characteristic of excellent healthcare environments in the second half of the twentieth century (McIntyre et al. 2020). The collective impact of these trends in some instances has been the effective erasure of "the creativity, judgement and indeed the very humanity that has necessarily and iteratively shaped the construct of professional nursing" (McIntyre et al. 2020: 7).

None of these transitions in healthcare practice has occurred in a vacuum or been the inevitable consequence of health system growth. The "science" of healthcare management has increasingly taken direction from the business sector rather than the health professional sector, and health managers have found governments highly receptive to their arguments that insights about efficiency and effectiveness from the study of industry will have direct application to cost savings in healthcare. Since the health portfolio is conspicuously the largest of all provincial government expenditures, bureaucrats have been eager to sign on to the corporatization agenda, including the idea of "breaking down silos" within the health professions in order to minimize their influence on the evolving strategic decision-making process (Graban 2019). We have seen, therefore, fewer "director of nursing" or "chief nursing officer" positions in our hospitals and health authorities. Where these positions are retained, they are often at a lower level of executive decision making than is needed to be strategically effective. Alternatively, when nurses are positioned in senior executive roles, their remits are typically explicitly interprofessional, such that it would be considered bad form to focus attention on the structure and development of their own discipline. Beyond executive tables, we see the erosion of "nursing systems" throughout our healthcare organizations. Rather than reporting to more senior nurses as their professional leaders, early- and mid-career nurse managers may now report to an "operations lead" – someone who, regardless of disciplinary background or expertise, is tasked with making decisions that directly shape the conditions for everyday nursing practice. Thus, nursing is notoriously less likely than other relevant constituencies to have a powerful professional mentorship system within our healthcare organizations or a voice in the policy decisions that affect the profession (Drennan and Ross 2019; Prybil 2013).

Nursing has been a particularly hard-hit target by these corporate healthcare practices and philosophies (Rankin and Campbell 2006). Not only do we represent the largest healthcare workforce, but we also pose a pervasive threat to the intricate systems of policy regulation and standardization that allow for enforcement of the "efficiency" agenda in what has been termed the "McDonaldization" of nursing (Bradshaw 2016; Norlyk et al. 2017). In particular, we nurses have a profound and deeply embedded commitment to the idea that each patient is unique and that care excellence depends on the extent to which we can come to know and respond to each patient's unique context (Thorne and Sawatzky 2014). Thus, from a corporate perspective, this foundational feature of nursing inevitably leads to more expensive care, constituting an ideological flaw that is most easily dismantled when non-nurses assume control of the conditions for nursing practice (Kim et al. 2006). Nursing's inevitable response to these trends has been to protect the integrity of nursing care, and nursing is notorious for the "workarounds" it develops to try to sustain high-quality healthcare despite these tightening controls (Rossetti et al. 2019). Thus, we have seen the widespread proliferation of reporting requirements, standard protocols and "evidence-based" practice guidelines as devices to control and monitor the practice of nursing, seeking to change what most nurses would consider a highly skilled relational and moral practice into a routinized activity (Austin 2011).

During pandemic conditions, when the need for creative adaptation, professional solidarity, effective teamwork and skilled relational practice is heightened to the extreme, the levels of moral distress and frustration occasioned by these conditions of control have skyrocketed. To move forward and regain an appropriate level of involvement in the conditions that shape our profession, its practice and its capacity to contribute fully to the health of the population, it is patently apparent that we need a strong commitment to a renewed professionalism in nursing. When we examine the many forces that have eroded our professional voice and capacity over recent decades, we are compelled to confront the reality that nursing itself has been, to some extent, complicit in allowing this to happen. Thus, taking advantage of the current crisis to critically reflect on our profession and its evolution can help us open up possible paths for changing the course of our history toward positioning ourselves in a manner that can ensure we continue to fulfill the societal mandate we hold so dear.

Among the ingredients we must strenuously protect are the capacity for autonomous professional practice. Of course, as the ultimate team player within the system, nursing has rarely considered itself completely autonomous. Nevertheless, there are many aspects of practice over which nursing is the only viable source of expert wisdom, and we must never allow the conditions governing those aspects

to be co-opted by corporate managerial priorities or determined at administrative levels to which nursing lacks access. In order for autonomous professional practice to flourish, we need strongly embedded systems of new graduate support, mentorship and career development designed by nurses for nurses, with the understanding that all of these require a meaningful commitment to a highly educated nursing workforce and a strong cadre of nurses with advanced practice preparation, particularly in a clinical nurse specialist capacity. We also need nursing research, not simply within the academy but powerfully integrated into the practice and practice leadership context, such that answers can be sought for the questions nursing asks and the evidence-base for the immense contribution nursing makes to a highly functioning healthcare continues to build.

A strong nursing professional vision requires that we maintain an autonomous and self-regulatory philosophy, balancing the protection of the public (which, of course, we all support) with the capacity of the profession to take calculated risks to advance practice and support the creative attention to the evolving world of human health and illness that is our proud tradition. We need bargaining associations to secure appropriate conditions of work, but this needs to be done from the perspective of facilitating good practice, which does not set boundaries around itself in the manner of a traditional labour union. We need powerful and well-developed nursing professional associations, both at the provincial/territorial and national levels, to reflect the collective policy voice that our profession can bring to the full spectrum of decisions and directions that touch upon our practice. Also, we really do need all of these organizations working together in a collaborative manner toward a shared vision for the profession. Surely, in these times of rapid change and turmoil, the points of agreement that come from our love of this profession and our vision for what it can contribute to the larger health of society will allow us to overcome some of the historic internecine struggles that have so often made us our own worst enemy.

Moving beyond this pandemic, we need to work together to ensure a strong national policy office such that the nursing voice can consistently and strongly be heard within the federal government. It is most certainly time for nursing to "get loud" (Thorne 2021) or, in the immortal words of the 2011 Nobel Peace Prize winner Leymah Gbowee, at least to "stop being politely angry" (Sernaker 2019). We need that office to work collaboratively with our provincial chief nursing officers to coordinate messages and optimize our wider policy impact, especially in the evolving strategic priority areas. We need those individuals and offices fully supported by strong and powerful professional associations, even as we are undergoing a tremendous change in Canada with respect to how nursing will be structured and funded.

Conclusion

These are indeed interesting times. As has so often been the case throughout our history, such times create opportunities to rebuild our professional vision, renew our commitment to the common cause and join together in redefining our mission. Canadian nurses need evidence of strong, inspired and passionate professional leadership in order to reignite the spark of enthusiasm and optimism that will get them through this pandemic. They need confidence that their profession has regained appropriate control of its conditions of practice, such that, collectively, we have the capacity to make a meaningful difference in health and healthcare for all. The future of our profession, indeed our world, demands a vibrant, highly respected and well-supported nursing workforce, and that process begins with each of us.

Correspondence may be directed to: Sally Thorne, Professor, T201–2211 Wesbrook Mall, Vancouver BC V6T 2B5. Sally can be reached by phone at 604 822 7482 or by e-mail at sally.thorne@ubc.ca.

References

Austin, W.J. 2011. The Incommensurability of Nursing as a Practice and the Customer Service Model: An Evolutionary Threat to the Discipline. *Nursing Philosophy* 12(3): 158–66. doi:10.1111/j.1466-769X.2011.00492.x.

Bradshaw, A. 2016. An Analysis of England's Nursing Policy on Compassion and the 6Cs: The Hidden Presence of M. Simone Roach's Model of Caring. *Nursing Inquiry* 23(1): 78–85. doi:10.1111/nin.12107.

Drennan, V.M. and F. Ross. 2019. Global Nurse Shortages—The Facts, the Impact and Action for Change. *British Medical Bulletin* 130(1): 25–37. doi:10.1093/bmb/ldz014.

Graban, M. 2019. Lean: Breaking Down Barriers for the Sake of Improvement. *International Journal for Quality in Health Care* 31(Supplement_1): 1–2. doi:10.1093/intqhc/mzz112.

International Council of Nurses (ICN). 2021. *Policy Brief: The Global Nursing Shortage and Nurse Retention*. Retrieved August 29, 2021. <https://www.icn.ch/system/files/2021-07/ICN%20Policy%20Brief_Nurse%20Shortage%20and%20Retention.pdf>.

Kim, C.S., D.A. Spahlinger, J.M. Kin and J.E. Billi. 2006. Lean Health Care: What Can Hospitals Learn from a World-Class Automaker? *Journal of Hospital Medicine* 1(3): 191–99. doi:10.1002/jhm.68.

McIntyre, J.R.S., C. Burton and D. Holmes. 2020. From Discipline to Control in Nursing Practice: A Poststructuralist Reflection. *Nursing Philosophy* 21(4): e12317. doi:10.1111/nup.12317.

Molina-Mula, J., E. Peter, J. Gallo-Estrada and C. Perelló-Campaner. 2018. Instrumentalisation of the Health System: An Examination of the Impact on Nursing Practice and Patient Autonomy. *Nursing Inquiry* 25(1): e12201. doi:10.1111/nin.12201.

Norlyk, A., A. Haahr, P. Dreyer and B. Martinsen. 2017. Lost in Transformation? Reviving Ethics of Care in Hospital Cultures of Evidence-Based Healthcare. *Nursing Inquiry* 24(3): e12187. doi:10.1111/nin.12187.

Prybil L.D. 2013. Nurses in Health Care Governance: Is the Picture Changing? *Journal of Nursing Care Quality* 28(2): 103–07. doi:10.1097/NCQ.0b013e31827efb8b.

Rankin, J.M. and M.L. Campbell. 2006. *Managing to Nurse: Inside Canada's Health Care Reform*. University of Toronto Press.

Rossetti, S.C., P-Y. Yen, P.C. Dykes, K. Schnock and K. Cato. 2019. Reengineering Approaches for Learning Health Systems: Applications in Nursing Research to Learn from Safety Information Gaps and Workarounds to Overcome Electronic Health Record Silos. In K. Zheng, J. Westbrook, T.G. Kannampallil and V.L. Patel, (Eds.), *Cognitive Informatics: Reengineering Clinical Workflow for Safer and More Efficient Care* (pp. 115–48). Springer.

Sernaker, E. 2019, June 24. The Ms. Q&A: How Leymah Gbowee Turned Anger into Action. *Ms Magazine*. Retrieved October 14, 2021. <https://msmagazine.com/2019/06/24/the-ms-qa-how-leymah-gbowee-turned-anger-into-action/>.

Silas, L. and V. McKenna. 2021, August 23. Nurses in Ontario – and across the Country – Call for Action on Staffing Crisis. *The Hamilton Spectator*. Retrieved August 29, 2021. <https://www.thespec.com/opinion/contributors/2021/08/23/nurses-in-ontario-and-across-the-country-call-for-action-on-staffing-crisis.html>.

Thorne, S. 2021. Time to Get Loud. *Nursing Inquiry* 28(1): e12400. doi:10.1111/nin.12400.

Thorne, S. and R. Sawatzky. 2014. Particularizing the General: Sustaining Theoretical Integrity in the Context of an Evidence-Based Practice Agenda. *Advances in Nursing Science* 37(1): 5–18. doi:10.1097/ANS.0000000000000011.