How do we define ourselves? A feminist perspective on the positioning of ‘care’ within nursing research strategic goals.

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At a recent meeting between our local nursing deans, key academics and directors of nursing from several local health districts, we discussed the best way to position nursing research within the “Sydney Health Partners”; a medically-driven translational research partnership (Leeder 2016) spanning the greater Sydney area. There were concerns by some nurse leaders that presenting our nursing research strategy in terms of ‘compassionate, patient and family-focused care’ would be seen within a broader multidisciplinary, strategic alliance as lacking cutting edge clinical relevance and scientific credibility.

The historical positioning of nursing research, and the identity of nursing research leaders, stems firstly from our understanding of ourselves as a profession; secondly from the gendered construct of nursing work; and finally, from the positioning of nursing against the dominant discourse of medicine and biomedical, positivist research. This paper explores the strategic positioning of nursing research within broader hegemonic structures and provides a critical analysis of nursing’s denial of its central caring tenets.

Care and gender

As with other female-dominated service occupations, nursing work is socially constructed as relational, altruistic and maternal, whereas men are more likely to work in roles that are professionally competitive, self-interested and oppositional (Green 2012). In nursing, diverse patterns of understanding and behaviours around care arise from our experiences of gender, culture, power and politics, and are embedded in both personal and social values (Green 2012). Relationships are central to the notion of care, which is defined through the gendered and socially constructed nature of our lives (Belenky et al. 1986, Gilligan 1982, Green 2012).

Caring from a masculine standpoint has been situated philosophically as a moral duty or as a characteristic of natural justice. Feminist theory situates care within the context of relationships, constructed within culture and society, and shaped by political and structural environments (Belenky et al. 1986). The feminist standpoint challenges those power relations and resulting domination that manifests not only in nursing practice, but also within health institutions and academia (Kuhse et al. 1998).

Relationships provide the core theoretical, intellectual and heuristic basis for care in nursing science. Care has been described as a communicative process, a commitment to the alleviation of vulnerability, and a construct that requires concern and accountability (Bowden 2001). It has also been described as seeking ‘power-with-others’ versus ‘power over-others’ (Green 2012). There does, however, remain a substantial theoretical ambiguity around the notion of care when this term is used in the context of nursing epistemology (Bortoff 1991). Nursing discourse has situated caring using a “virtue script” (‘good work done by good women’) (Nelson 2012): this constitutes a failure of nursing to grapple with, and communicate, the specialist skills and epistemology that defines nursing work versus the public construction of the humane and caring face of nursing. This failed integration has served to undermine the importance and value of nursing epistemology among those receiving care, to their detriment (Gordon & Nelson 2005). However, it is both possible and imperative to combine both care and science. This requires us to find rigorous methodologies in which to situate our inquiry into caring practices, and practical applications for meaningful translation. It also
requires a willingness to strategically place ourselves as leaders in nursing within the medically-dominant research culture of health without losing our unique identity.

The social construction of nurses as subservient

Care is a political concept for nursing, as nursing practice occurs within relationships and is dependent on resources provided by political structures. Within these political structures is a hierarchy that positions medicine as the dominant power. An early conceptualisation of “the Doctor/Nurse Game” proposed by psychiatrist, Leonard Stein (1967) describes the social game played between disciplines to both implicitly and explicitly maintain the balance of power in favour of the medical profession. This early observation saw doctors responsible for the heroic work of curing the patient, and the nurse ‘mopping brows and folding pillow cases’. This concept resonates with ongoing constructions of healthcare: anyone who has viewed the Australian hospital reality TV show “RPA” will note that nurses are rarely presented in the role of healers.

Stein’s first conceptions of the Doctor-Nurse Game plays out as follows: the nurse takes initiative and makes bold recommendations for patient management while appearing passive, supported by subtle non-verbal cues. This must be carried out in such a way that the nurse does not appear to make a recommendation statement, and while the physician may seek a recommendation, “he” does so without appearing to ask for it. Open disagreement is avoided at all costs. Stein’s ‘game’ has a scoring system, however it is not simply a traditional ‘one wins, one loses’ system. Rather, the rewards and punishments are equally shared. If the game is played successfully, the physician has access to the nurse’s skill, while the nurse gains a sense of self-worth and job satisfaction. At its best, the Game creates an alliance, where the physician has the respect and support of the nursing service, smoothing the path for effective physician work with ‘pet’ routines followed, systems organised and patients and families pacified. The nurse in return is openly acknowledged as a “damn good nurse” and enjoys a position of respect.

It was the socialisation of nurses that fostered their acquiescence in the Game (Roberts & Group 1995), with traditional, apprenticeship-style training designed to nurture subservience and discourage deviant behaviours. Student nurses had meal-time and lights-out hours strictly enforced. Meaningless chores and standards were prescribed around the appearance of bedlinen, with the relationship between student and instructor having a strong military flavour. Australian nurse academic, Judy Lumby (2001, p. 19) recalls, “We were not allowed to engage the patients in ‘small talk’... I was forbidden to speak with doctors... We stood aside for doctors, just as we stood aside for the head nurses, with hands behind our backs and eyes averted”. The likely purpose, and certain result was that nurses were socialised to have a fear of independent action, particularly when relating to physicians. There was a tension between their framing as an invaluable aid to the physician, and their need to not offend or belittle (Stein 1967). Both doctor and nurse were shaped by what Foucault might describe as ‘normalising judgement’ where little punishments are metered out to those who don’t conform, making examples of an individual’s failure while keeping hidden the mechanisms by which power is exerted (Foucault 1995, p. 184).

Challenging nursing subservience

Stein et al later revisited the Doctor/Nurse Game (1990), seeing several historical developments partially eroding the rules. The notion of medical omniscience has declined with the
commercialisation of health care challenging the concept of medical altruism. With an increase in the complexity of medical knowledge, and a move towards specialisation, the fallibility of physicians is increasingly recognised, with no one person able to internalise the breadth of health knowledge. The worth of nursing as a profession has been elevated, with the necessity of a strong nursing workforce highlighted in the 1980s and 90s: the shortage of nurses threw a spotlight on firstly, the intrinsic value of nurses to the healthcare system, and secondly, on industrial conditions that made the job less attractive, including relatively small financial rewards and limited clinical autonomy. Given the growing array of alternative career opportunities for women, the nursing shortage provided an important imperative to attract a new cohort to the profession and to retain high quality staff by strengthening career opportunities. The strengthening of career paths, particularly in specialist units such as the intensive care unit and emergency department, has made explicit the specialist nursing knowledge that supports multidisciplinary practice.

At least in some quarters, nurses have stopped playing the Nurse/Doctor Game. The growing visibility of nurses in management structures and their importance in service development and systems means they are not as reliant on physicians to afford them their sense of worth and respect. The centrality of nursing to quality improvement and accreditation processes provides both a platform for critique of medical processes, and a challenge to the assumption of authority in medical decision-making (Stein et al. 1990). The changing gender profiles in nursing, medicine, and more broadly in the academic community further challenge the Game. In Australia, female university graduates now exceed those of men by 20% (Martin 2015), and in medicine, women make up more than half of Australia’s medical graduates (Medical Training Review Panel 2010). Similarly, men are entering the nursing profession in increasing numbers as the career opportunities offered are broadened. Around 10% of Australian nurses are men with representation of around 14% in critical care environments and in management roles (NMBA 2016). Men in nursing are credited with bringing a normative balance to the ‘emotional and social culture of the workplace’ (NSW Nurses & Midwives Association 2012).

Arguably, the university preparation of nurses has broken the process of subservient socialisation with new graduates not understanding that they are supposed to be submissive. The focus on evidence-based care means that knowledge is no longer held by the omnipotent physician, but is available to anyone who wishes to perform a literature search, levelling knowledge as the primary source of power.

**Claiming nursing space and credibility in health research**

Nursing academia has tended to critique medicine for its narrow biomedical focus on the diagnostic and curative elements of disease. In contemporary practice, rather than seeking direct competition with the medical profession, nurses have chosen to focus on disease prevention, health promotion and a family-centred approach to chronic illness management (Stein et al. 1990). This is not only a more intuitive ‘fit’ for nursing, but is also the only place where autonomous nursing specialists are allowed to sit in the turf wars created by nurse practitioner roles (Lowe et al. 2012). Nurses are ‘allowed’ to take over medical duties where they are positioned to solve access and equity issues, or where they can reduce unmanageable physician workload.

While the clinical area is not the gendered battleground that it once was, there are new areas of contention as nurses seek to build an evidence base for their own unique practice. Nursing has developed into a strong and vibrant academic field with a growing number of higher degree research students, nurse-focussed academic journals, and hospital-based professorial chairs. This places nurses in the highly competitive, multidisciplinary research arena where they must now find visibility
in the research strategic plans of their organisations and must also compete for the ever dwindling research funds. In Australia, the largest funder of health & medical research, the National Health and Medical Research Council (NHMRC), has a funding success rate of less than 15%, dropping from nearly 23% in 2009 (AAMRI 2014). While many productive nurse researchers manage to survive ‘on the smell of an oily rag’, funding success is an important output measure for both universities and health institutions. For nursing, funding success relies on our ability to articulate strong research collaborations and saleable research ideas. This means we need to be particular and strategic in the way that we describe what it is we do, and the importance and impact of our work. This suggests there is a new Doctor/Nurse game that requires us to play with the ‘Big Boys’; we do, however need to decide whether to accept their rules.

Strategic research plans in medically-dominated settings tend to be disease-focussed. For example, the aforementioned Sydney Health Partners collaboration has thematic lines of cancer, liver, cardio-metabolic, infectious diseases, renal transplant, neurosciences and mental health. Cross-cutting themes include biobanking, education, clinical trials, informatics, genomics and operational enablers (Leeder 2016). Finding a place for nursing to slot into such a framework with our own voice is difficult. While nurses may conduct research into prevention, processes and management of specific diseases, much of our work can and should cut across these silos. In our Sydney Local Health District, the Nursing Research Priorities comprise clinical practice, technology and informatics, patient and family experience and workforce and systems. These are bound by an overriding principle of ‘patient and family-centred care’. Claiming “care” as our central tenet was controversial when we communicated this to a meeting of influential nurse members of the Sydney Health Partners. There were concerns that we would not be taken seriously, and that we should drop our “little nurses projects” – a comment directed towards both practice development projects, and local clinician-initiated research that often act as the foundation for research capacity-building. This illustrates our creation of a nursing cultural cringe where we continue to internalise an inferiority complex, dismissing our strength and focus on care.

The need to develop strong nurse leaders in research

As nurse leaders in research we need to overcome our own cultural cringe – a process that calls for reflection on our own positioning within a medically-dominated culture and the structures that extend the Nurse/Doctor Game to the research world. While dominating health workforce numbers, nurses remain underrepresented in authoritative committees, and political processes that distribute organisational power. This results in a scarcity of role models and mentoring opportunities for those seeking leadership skills and roles (Daly et al. 2015, p. 38). Even in the contemporary business world, the career success of women has been attributed to how they are developed, coached and mentored early in their career (Carter & Silva 2010). The potential for strong nurse leadership in research has benefits for more than just the nursing profession. It is recognised across sectors that the more diverse the talent, the greater the likelihood of innovation and business success (Carter & Silva 2010). It is, however, notable that women have difficulty internalising a leadership identity. The subtle gender biases that underlie organisational culture disrupt the cycle of leadership development where a person begins by taking a decisive action, followed by others affirming that action, which encourages future assertions of leadership. These interactions feed into the potential leadership identity, which in the beginning is a tentative and peripheral aspect of self. Positive experiences of early leadership initiatives will inform the likelihood of the future leader stepping outside of their comfort zone, experimenting with unfamiliar behaviours or developing innovative expressions of leadership (Ibarra et al. 2013).
At the heart of the issue is that feminine characteristics are not seen as desirable in leadership roles (Ibarra et al. 2013, Powell 2012), with women encouraged to “think male” (Robbins & Coulter 2013), displaying ambition, dominance, decisiveness, rationality, aggression and logic; all excellent attributes for high-profile, highly-funded research investigator roles. These are contrary to the qualities valued by females comprising inclusivity, connectedness and relationship-building (Hoss et al. 2011). Even men in nursing are sidelined by the gendered construct of their profession.

At this time in our profession’s history, we could choose to create our own rules for the Game, with perhaps the greatest potential for nursing research leadership centred on the empowerment of others. Empowerment has been proposed as a participatory leadership strategy that transfers accountability, responsibility and authority to others to allow organisational goals to be met. It is essentially positive and solution-focussed rather than problem-focussed. It does require the empowered professionals to have some level of commitment, initiative, capability and autonomy in decision-making, factors that may be impeded by the workplace organisation and culture (Daly et al. 2015, p. 41). Leadership styles that rely on referent and expert sources (where target individuals are inspired by the insight and expertise of leaders) are more likely to have teams that are motivated, satisfied and successful (Wood et al. 2012). In an examination of a positive, enabling nursing research culture, ‘non-competitiveness’ was defined as a key characteristic (Wilkes et al. 2013). This reinforces the important role of research-capacity building and mentorship over the ‘cult of personality’ that promotes funding track-record over all else.

Nursing’s ownership of sound, philosophically-based qualitative research allows us to find our caring voice. While this does not and should not exclude us from positivist questions and designs, it does allow us access to new frameworks for research funding that value mixed-methods approaches and provide opportunity for subsequent involvement in multi-disciplinary research teams. In both government and accrediting bodies, an increasing value has been placed on the perspectives of ‘people’ with patients and families objecting to the depersonalisation, the exclusion from decision-making and their lack of access to their own health data (Morse 2016). An example of the growing value of person-centred inquiry is the systematic collection of patient stories now held by the National Library of Medicine (Morse 2016).

Research that informs nursing care seems diminutive alongside the mega-funded positivist projects of medicine; indeed, the concerns of nursing research are marginalised by structures such as our Medical Research Institutes – the social, political and economic powerhouses of clinical knowledge production. The patriarchal, gendered construction of nursing care and research makes us ashamed of our distinctiveness so that we “become alienated to ourselves” (Belenky et al. 1986); apologists for our caring work and inquiry. We now need to define who we are, to stand firm in our commitment to care, and to research that care in clear, meaningful and intelligent ways. This means confident collaboration with our medical colleagues, but also a continued and unapologetic focus on, and partnership with, the person as the embodied bearer of illness and injury, and as the recipient of care.

References

AAMRI (2014) NHMRC Project Grant success rate of just 14.9 per cent highlights need for the Government’s Medical Research Future Fund. Association of Australian Medical Research Institutes.


Green B (2012): Applying Feminist Ethics of Care to Nursing Practice. Journal of Nursing Care 1, 111.


