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# An Exploration of Nursing Disillusionment

**Kathleen Oberle and Betty Davies**

Le cadre d'analyse de certaines des difficultés courantes que rencontrent les professionnels des sciences infirmières est constitué d'un modèle de soutien positif élaboré dans une précédente recherche et d'une théorie de l'éthique. Les auteurs affirment que la cause principale de la désillusion du personnel en sciences infirmières est la discordance entre les valeurs personnelles qui sont enracinées dans la déontologie des soins et un système de soins de santé qui valorise la compétence technologique plutôt que les valeurs humaines.

A model of supportive care developed in prior research, combined with ethical theory, is used as a framework for analyzing some of the current problems facing the nursing profession. The authors argue that a central cause of nursing disillusion is dissonance between personal values rooted in an ethic of caring and a health care system that rewards technological competence above human values.

Among nurses, particularly those in acute care settings, disillusionment, frustration, and burnout have become common. Why are so many nurses unhappy with their profession? In this paper the authors examine results of their previous research in an attempt to find some answers. Based on a model of supportive care developed in the earlier study (Davies & Oberle, 1990; Oberle & Davies, 1992), the authors propose that a central cause of nursing disillusionment is a health care system that repeatedly forces nurses to betray their personal values in the context of their professional practice. The model's various components can be used with recent ethical theory to explore the possibility that the erosion of personal integrity places the individual nurse in jeopardy. According to recent literature, and the authors' own current research, nurses who maintain a personal ethic that is rooted in caring and nurturance often become frustrated and dissatisfied in a system that rewards technological competence above human values.

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## The Model

The earlier-mentioned supportive care model was developed using grounded theory methods, through which the authors examined the expert care provided by one nurse to 10 palliative care patients and their families. Six interwoven but discrete dimensions of care were identified: *valuing, connecting, empowering, doing for, finding meaning, and preserving integrity* (Figure 1). Details of the study are described elsewhere (Davies & Oberle, 1990; Davies & Oberle, 1992; Oberle & Davies, 1992). Of these six dimensions, some are primarily attitudinal, while others are more task-oriented. *Valuing* is an attitude that affects all the nurse's activities; *valuing* it means having respect for the inherent worth of others. Although it is possible to provide nursing care without *valuing*, it would be incomplete or inadequate to meet patient needs.

Whereas *valuing* is the encompassing dimension, *preserving integrity* is central to the model because it is integral to the nurse's effective functioning. It involves the nurse's maintenance of a sense of wholeness, self-worth, and self-esteem. At the same time, preserving integrity is patient-centred, for it is related to the wholeness of the patient, and in fact, is the goal of nursing care. It is in keeping with more usual definitions of the goal of nursing as the maintenance of the patient's physical,

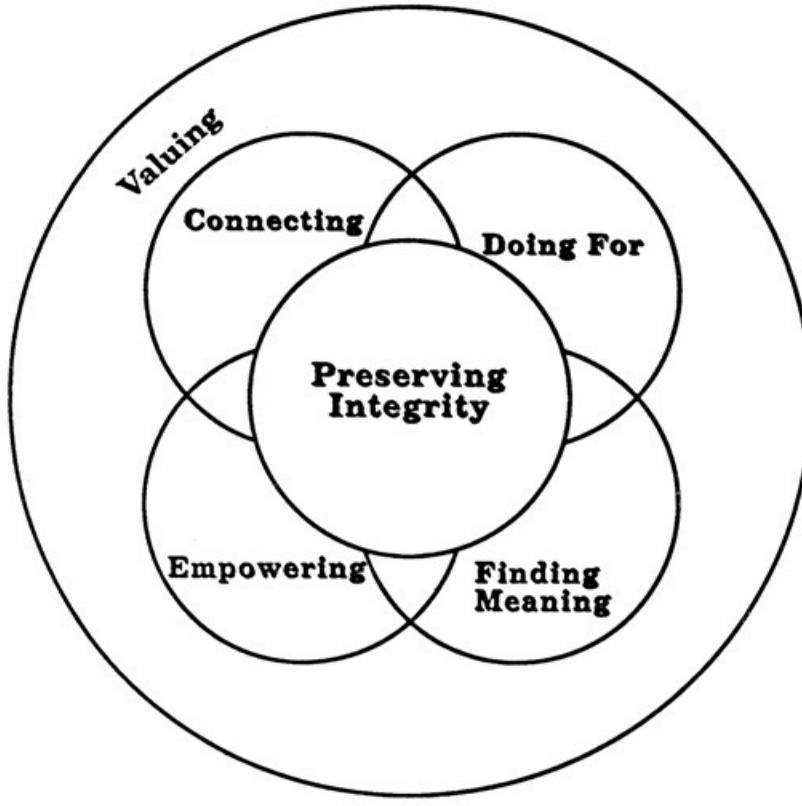


**Figure 1: Dimensions of Nursing Care in the Supportive Care Model**

emotional, and spiritual well-being (Quinn, 1989). *Valuing* and *preserving integrity* are enacted through the four action components of the model: *connecting, empowering, doing for and finding meaning.*

*Connecting* means getting in touch with, or establishing a bond or relationship with the patient and family. *Empowering*, or helping the patient and family to do whatever it is they need to do, is strength-giving or energizing, rather than tangible or task-oriented. The nurse has an armamentarium of skills and knowledge from which the patient/family take what they need. Exactly what the individual patient finds *empowering* depends on the person, and is not defined by the nurse. *Finding meaning* is closely related to *empowering*. It involves helping patients and their families to develop a perspective on the health problem and its role in their lives, and helping patients make sense of what is happening to them.

*Doing for* focuses on the physical care of the patient. This is the aspect of nursing that receives the most attention in the literature, in practice, and in educational settings. When *doing for*, the nurse uses resources that are extrinsic to the patient and family, whereas *empowering* draws on their intrinsic resources. In Figure 1 the overlap of the circles indicates that the dimensions are interwoven and difficult to separate. For example, when the nurse connects with the patient this implies that she or he values the patient as an individual, which could help the patient find meaning, and thus be empowering. Similarly, *doing for* can be empowering if the patient is in need, that is, if the patient is unable to do for self. However, too much *doing for* can become disempowering if the nurse does that which the patient has the ability and will to do. Therefore the nurse must be constantly alert to the interactions among the dimensions.

The supportive care model was developed to explicate the clinical role of a nurse. However, nurses in other practice settings reported that the model was useful as a basis for orientation programs and teaching undergraduate nursing students. One psychiatric hospital based its nursing mission statement and philosophy on the model, and many nurses have indicated that it renewed their enthusiasm for nursing. Thus, nurses in practice have validated the model, suggesting that it accurately reflects the essence of nursing practice.

## Nursing Disillusionment

In the context of the disillusionment of nurses, the importance of *valuing* becomes increasingly clear. The holistic nursing care described by this model demands that the nurse believe in the intrinsic worth of the individual(s) being cared for. Thus, the model suggests that *valuing* is foundational to the concept of excellent nursing practice, and defines its ethos. Belief in the intrinsic worth of others is a very personal

experience. Excellence in nursing therefore depends on a congruence between the nurse's personal belief system, or ethic, and the values espoused by the profession.

The interconnection between personal and professional values can be better understood in light of ethical theory. Traditional views of ethics suggest that it focuses on "justice," that is, the application of abstract principles and rules. In the established justice perspective, relationships are essentially unimportant, and caring is a confounding factor (Kohlberg, 1981; Kohlberg & Candee, 1984; Rest, 1982, 1987). However, a number of scholars have recently described another view of moral development in which connectedness and caring are seen as cornerstones of a way of thinking about the world. They have proposed that either a justice or a caring orientation will predominate in any one individual (Baier, 1987; Gilligan, 1982, 1988a, 1988b, 1988c; Meyers & Kittay, 1987; Noddings, 1984). This thinking, which is relatively new in philosophical circles, suggests that caring can be at the centre of a personal belief system. If the arguments of these scholars are correct, and it is possible to have an ethic based on caring, and if caring is central to nursing, as has been suggested (Benner & Wrubel, 1988), then the foundational ethic of nursing must be one of care (Fry, 1989; Gadow, 1985). If nursing professional values are based on an ethic of caring and connecting, then the nurse holding an ethic based on care will find personal values congruent with professional values.

The supportive care model can be used to demonstrate the foundational relationship between an ethic of care and nursing practice. In the model, *connecting, empowering and finding meaning* are action components that appear to be "rooted in receptivity, relatedness, and responsiveness" (Noddings, 1984, p. 2). When *doing for* is linked with these dimensions, it becomes another manifestation of a caring ethic. The core of the supportive care model is *preserving integrity*, which is the nurses's ability to maintain a personal sense of coherence or oneness, while at the same time helping maintain the patient to wholeness. This overlap of the nurse's goals for self and patient care makes personal values central to nursing care. In this construction, the nurse's sense of professional worth must be tied closely to the type of care she/he provides, and the nurse must be true to personal values to maintain a sense of personal worth. In order to maintain an ethic based in connectedness and nurturance, the nurse must put values into practice by providing holistic care.

By this reasoning, the action components of the model and the *valuing* and *personal integrity* components are inextricably linked through the patient-nurse relationship. Nursing activities must be in concert with the values of both patient and nurse. If connectedness and caring are nursing values, then they must be actualized by nursing activities. Clearly, there must be a balance between actions and values; the nurse cannot focus only on the interpersonal aspects, nor exclusively on the physical tasks.

This argument may provide some insights into the discontent many nurses, particularly those in acute care settings, feel with their profession. For the nurse whose personal belief system is rooted in caring, ethical nursing, care could be defined in terms of the supportive care model. However, the nurse's work environment may not be conducive to providing the kind of care defined by the model. In hi-tech acute care settings, the nurse may experience little support for practicing the personal and professional values of caring and connectedness. The result is a lack of fit between what the nurse feels should be done and what she/he is able to do within the limits of the system. This can lead to what has been called cognitive dissonance, a discomfort experienced when situations are logically or psychologically incongruent with one another. Dissonance is so uncomfortable that the individual will take extreme measures to reduce it, e.g., by lessening the importance of one of the opposing forces or cognitions (Schneider, 1976).

In the supportive care model, the *doing for* component incorporates the tasks and technologies that are so much a part of a nurse's work life. When the institutional system confines the nurse's focus to *doing for*, as when reward and recognition are primarily for task-oriented activities, it becomes increasingly difficult to incorporate other dimensions into care. If the nurse as person believes that complete care is important, and that it consists in all four action components, then dissonance results.

One way the nurse can reduce dissonance is to change her or his view of what should be done. When faced with too many tasks and insufficient time, the nurse may find it necessary to downplay the importance of *connecting, empowering*, and *finding meaning*. The nurse focuses on *doing for*, either because it is encouraged and rewarded, or because time permits nothing more. In effect, *doing for* becomes disconnected from the other components and moves outside the *valuing* context (Figure 2). However, by distancing *doing for* from a caring ethic, the nurse betrays deeply held personal and professional beliefs, and the result is an erosion of personal integrity. Thus the nurse's unconscious effort to reduce dissonance by devaluing the caring and connecting aspects of care has a boomerang effect. Much attention has been given to the personal cost of caring (Forrest, 1989; Warren, 1988), but little notice has been paid to the obverse, the personal cost of not caring. When the system of values within the organizational culture is different from that held by the nurse, the cost to the nurse is high (Morrison, 1989).

Another point may help to explain the distress experienced by nurses in the work place. When the supportive care model was developed, the data indicated that through *connecting, empowering*, and *finding meaning* there was a mutual exchange of energies that was essential to the maintenance of the nurse's personal integrity. The enrichment and empowerment that the nurse got from the patient gave her or him the strength to continue despite the high cost of caring. In making a true connection with the patient, and sharing the patient's experience, the nurse was

likewise empowered. Thus, the model suggests that when the nurse is constrained to focus on the *doing for* aspect of care at the expense of the other components, she or he experiences a betrayal of personal values and is denied the primary source of satisfaction and energy that is experienced when complete care is provided. Lacking a sense of personal accomplishment, nurses become emotionally exhausted and, in the popular phrase, burned out (Williams, 1989).

## Costs to the Caregiver

Is betrayal of personal integrity a cause of nursing disillusionment? Support for this contention is found in an recent study where nurses in an acute care institution were asked to describe ethical problems they had experienced in practice (Oberle, 1993). Interviews were tape recorded and transcribed. Preliminary analysis suggests that nurses are concerned about their inability to provide what they perceived to be quality care. One nurse talked about what happens when she has too little time to give complete care:

> ...When I ...do that which I know to be the best, ... I have a tremendous sense of accomplishment and of righteousness ...

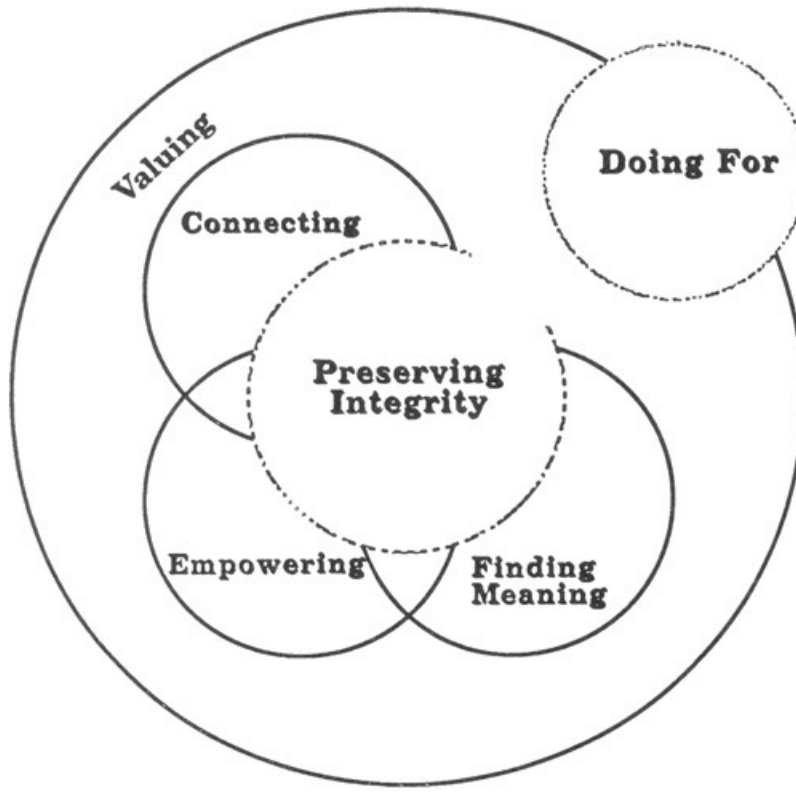


**Figure 2: Effects of Overemphasis on "Doing For"**

> treating my patients as a very human person. And when I don't, I feel I'm definitely dehumanizing them and I'm dehumanizing myself ... it does hurt me when I know that we're treating them that way.

Another nurse expressed similar sentiments:

> It seems to be an ethical problem to me because I'm caught between what I know I feel is right, which I think is an ethical situation, and between the practical implications of how I would define for myself the right to do what I consider an appropriate behavior.

Parker (1990) suggests that nurses who try to enact an ethic of care within a traditional intensive care setting feel considerable distress. Such distress may cause nurses to leave the particular work setting, or the profession itself, as exemplified by the following quotation from the ethics study:

> ... I know I looked after this person for three 12-hour shifts in a row and I really questioned whether nursing in this capacity, would I want it any more. It was the one time in my whole nursing that I thought, I don't believe in what we're doing...I almost quit nursing over it... you think, can't you see what's going on in here, are you so tunnelled that there's just the one thing you're involved with and you can't see the patient as a person any more...

Parker (1990) concludes that "many nurses have taken their stories underground to maintain personal integrity or to avoid devaluation. Stories once spoken with passion have been silenced...by the threat of being ignored, intimidated, or judged morally inept" (p. 39). As one nurse in the ethics study put it:

> I tried to bring this up with people I worked with but I felt that there was a conspiracy of silence. That these were issues that you didn't dare look in the face because they had implications...the implications for me were that I eventually left. That was my choice. And I left under an incredible strain. I felt very alone. I stopped, quit nursing for six months. ... I just realized that it wasn't the place for me ... I couldn't justify my part in that system. So there was no room for my personal philosophy there, and I felt that what I was doing was betraying it.

Nurses in the ethics study repeatedly emphasized how their inability to provide holistic care caused personal distress. When they felt their caregiving was being

driven by technology, rather than by patient needs, they experienced feelings of confusion, anger, and hurt.

## Discussion

Although numerous causes of nursing disillusionment have been suggested, researchers have found significant relationships between perceived stress, job satisfaction, and burnout symptoms (Cronin-Stubbs & Rooks, 1985; Norbeck, 1985). However, in these studies great variability of burnout symptoms was only partly explained by the measures used. Norbeck (1985) indicated that a more complete model was needed to explain the occurrence of dissatisfaction and burnout. One factor that could be considered is ethical distress, or what has been described in the current paper as an erosion of the nurse's personal integrity. According to Cameron (1986), "There are a lot of reasons for nursing burnout ... but ethical anguish has become a special weight of the past decade .... There may be a very strong, direct conflict between what the nurse thinks should be going on and what she's actually doing .... " (p. 42B).

## Conclusion

The current paper used the model of supportive nursing care to explore possible reasons for the current dissatisfaction of nurses in acute care settings. The purpose was to show how one conceptualization of nursing practice could be used as a tool to examine and articulate sources of nurses' distress. It was argued that nurses whose belief system is rooted in caring and connectedness believe that this ethic is enacted in the professional context by providing complete care, which incorporates all the action components of *connecting, empowering, finding meaning* and *doing for.* When they are prevented from providing the kind of care they believe in, they experience a betrayal of personal values. The result is nurses who are disillusioned and dissatisfied.

In searching for causes of, and solutions to current problems in nursing, attention must be paid to the nurse's need to maintain personal integrity. This could prove to be a fruitful area for future research. In a study of moral decision-making among lawyers, subjects who expressed values consistent with an ethic of care experienced greater moral distress in the context of their professional lives than did those whose moral orientation was justice-oriented (Jack & Jack, 1989). In the current paper it was suggested that an ethic of care is positively related with excellence in nursing practice. However, it has also been suggested that individuals who hold an ethic of care may be at increased risk for burnout in a system that is technology- and task-oriented. It would be illuminating, therefore, to explore how moral orientation

relates to quality of care nurses' perceived stress (or distress) in particular work environments. For example, one might ask whether care or justice orientations are related to the degree of difficulty nurses experience when deciding whether to continue treatment of critically ill patients. Alternatively, one might wish to examine the association between perceived dissatisfaction, moral orientation, and the emphasis on *doing for* in the work environment.

Thus, the supportive care model could prove to be useful for formulating research questions about nurses' disillusionment. If the problems can be adequately conceptualized, it may be possible to find their solutions through research.

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