Volume 46 Nº 3

CJNR

September / septembre 2014

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CJNR 2014, Vol. 46 Nº 3, 3–5

EDITORIAL

Patient- and Family-Centred Care: Some Solutions

Just under a year ago I wrote an editorial, using a personal tone, about a big problem we are facing in health care today. For all the talk of patient and family well-being as the raison d'être of health services, true concern for the struggles of those seeking help from the health-care system is sadly lacking in many settings in Canada and worldwide. I wrote about excessive wait times for both the most basic and the most complex health services, the dearth of primary care providers, and a distressing tendency of staff to avoid speaking to or even making eye contact with patients and families, as well as safety issues such as failure to pass on key information to patients, family members, and health-care workers. I also wrote about a creeping sense of hopelessness — the feeling that the status quo is just "the way it is." I argued that, as recipients as well as providers of care, we have an obligation to start fighting back and turning sentiment into action.

I wrote that editorial from a very personal viewpoint, at a time when I was grieving the loss of a cherished family member and was engaged in much soul-searching about my work as a health-services researcher and teacher. Standing back almost a year later, after having made some life changes, I think it is time I offered a few suggestions for what we can do to move towards patient- and family-centred care, from the relatively easy to the complex and challenging.

Perhaps we should start with the simplest of my suggestions. I struggle with the idea that negative media portrayals of our profession (in television programs, journalistic reports, and advertisements) make it hard to attract new recruits to nursing. Members of the public and other health-care practitioners are left with the impression that our work is undemanding and that we are legitimate targets for mockery if not outright harassment. This renders it difficult to command the resources that nurses need in order to deliver high-quality care.

I leave it to you, the reader, to decide how much vigorous activism should be targeted at offensive portrayals of the profession (but I do urge you to consult the excellent blog www.thetruthaboutnursing.com and to read some of the thoughtful works on media images of nursing that a quick Internet search will place at your disposal). I leave it to you to decide whether advertisers and television networks should be targeted in media campaigns. But I do recommend, without hesitation, that you find ways, personally and through your professional organizations, to thank and even honour the many journalists, creative writers, and performers who develop richly textured and thought-provoking representations of nursing that force people to consider what patient-centred care means and nursing's place in it. This might seem a small step, but surely it is a step in the right direction.

My second recommendation is that you seek out at least one nurse manager and personally make sure that this individual knows how much her or his role in patient care is valued and appreciated. Common sense, in addition to copious research in nursing and other fields, tells us that frontline nurse managers, particularly in the hospital setting, are a powerful force in shaping quality of work life for health-care staff. Their actions play a vital role in those myriad decisions over the course of a shift that determine whether care is safe, humane, and right for each patient. At a time of financial and organizational upheaval in health care, with the near certainty that we are headed for even more turbulence, we must not lose sight of the fact that frontline nurse managers have one of the most essential and difficult jobs in health care. We know that they are working extremely hard and are suffering the same emotional exhaustion that clinicians are experiencing, yet we do not know how to help them do their work better. If patient- and family-centred care is to become a reality, nurse managers will need more than a pat on the back and fair pay. They will need a level of emotional support and professional development that in most settings we have not been providing consistently.

Now for my third and perhaps most controversial plea. If we really want a health-care system that puts the needs of patients and families first, we will send an unequivocal message to our political leadership — to our provincial legislatures and ministries of health — that enough is enough. Most of the voting public and, truth be told, most of those who provide care and manage services, are ignorant about where health-care money comes from, how it flows, and what the system's outcomes are. We have some highly talented Canadian journalists covering the health-care beat, but is their work being widely seen and read by voters and policy-makers? We have public support at the provincial and federal levels for data experts and statisticians, who gather impressive data on structures, care delivery, and health outcomes, but are their reports being read by sufficient numbers of people, particularly voters? Do voters know that we are spending huge sums on what is often mediocre care driven by short-sighted, even cowardly, political decisions intended mainly to help governments survive to the next election?

I am reluctant to propose spending less on health care. Perhaps what we are spending is appropriately scaled, given the importance of health to quality of life and given that a large proportion of the costs are driven by labour — and our health-care personnel do deserve fair remuneration. But the fact is, Canadians are spending staggering amounts of money on health. The amounts seem to plateau from time to time but are nowhere near stable. And statistics and anecdotal data alike tell us that we are oceans away from offering the public consistent access to high-quality services at reasonable cost. Again and again, we form consultation groups and set up commissions that generate documents stretching to thousands of pages. We allow members of various interest groups, including politicians, to shadowbox in the media around the dangers of becoming excessively American in our approach to care delivery while ignoring problems with hygiene, the condition of physical plant in our institutions, staff workload and its implications for wait times, and demoralized workers and managers who end their shifts feeling that they personally have failed when it is the institutional and political leadership that has fallen short.

If we are to move towards patient- and family-centred health care, as I wrote earlier, we will have to get at the root of why our system is the way it is and stop letting ourselves become inured to the stories of personal suffering being told by our patients and their families. The critical mass of these stories is sending us a message that we can no longer ignore. The media can be our allies in showing how nurses might better respond, along with our colleagues in the other health professions and other health fields, to the needs of patients and families. Our frontline nurse managers need to know that we appreciate how challenging their roles are and how vital their work is to the achievement of patient- and family-centred care.

I would argue, however, that our first step must be to stop letting elected politicians off the hook in addressing the highly complex and increasingly pressing problems in health care. Ours is a richly funded system. If by chance there are insufficient resources to provide the care that our patients deserve, then I would argue that we can remedy the situation by holding long-overdue discussions and making compromises about services, realizing that not everyone will be happy with the solutions.

The people in the best position to use the political process are the voters. If we are to achieve a truly patient- and family-centred health-care system in which nurses play a central and respected role, we will have to educate ourselves and each other, as well as the media and the public, and we will have to make voters see the urgency of holding elected officials responsible for the quality of services and the outcomes of our very complex and very expensive health-care system.

Sean P. Clarke
Editor-in-Chief

CJNR 2014, Vol. 46 Nº 3, 6–25

Shadows and Sunshine: What Metaphors Reveal About Aging With HIV

Rosanne Beuthin, Laurene Sheilds, Anne Bruce

Using narrative inquiry, the researchers interviewed 5 older adults on 5 occasions over a period of 3.5 years about their experiences of aging with HIV. The participants' stories were analyzed for metaphors. Individual metaphors reveal a complex, unique struggle: living between tensions of uncertainty and hope, facing death and living in the moment, and suffering hurt amidst the joys of evolving identity. The tensions are fluid, although time and life experience facilitate a shift towards reconciliation. An overarching metaphor across this group of survivors is shadows and sunshine: to survive and live in a fragile state, balancing multiple shadows such as stigma and side effects with joyful experiences of support and belonging. The findings suggest that when nurses invite stories of life experience and listen for language used, they build compassion and gain understanding of what support is most needed to honour the personhood of older adults who are HIV-positive.

Keywords: metaphors, HIV, aging, narrative inquiry

Résumé

D’ombre et de lumière : ce que révèlent les métaphores sur l’expérience de vieillir avec le VIH

Rosanne Beuthin, Laurene Sheilds, Anne Bruce

Utilisant une approche axée sur l’enquête narrative, les chercheuses ont réalisé des entrevues auprès de cinq aînés, à cinq reprises, sur une période de 3,5 années. Les entrevues portaient sur leurs expériences en tant que personnes vieillissantes vivant avec le VIH. Les récits des participants ont fait l’objet d’une analyse en vue de relever les métaphores. Les métaphores individuelles révélaient une lutte complexe et unique issue de tensions provoquées par le fait de vivre de l’incertitude et de l’espoir, de côtoyer la mort, de vivre dans l’instant présent et d’éprouver une souffrance parmi les joies découlant d’une identité en évolution. Les tensions sont fluides, bien que le temps et le vécu facilitent un virage vers une réconciliation. Une métaphore commune présente dans le groupe de survivants était celle de l’ombre et de la lumière, qui traduisait l’expérience de survivre et de vivre dans un état de fragilité, de composer avec plusieurs côtés sombres, comme le stigmate et les effets secondaires, et de vivre des expériences heureuses, comme le soutien et le sentiment d’appartenance. Les résultats de l’étude indiquent que les infirmières qui invitent les patients à partager leur vécu et qui portent attention au langage utilisé acquièrent un sentiment de compassion et comprennent davantage le type de soutien qu’elles doivent dispenser pour honorer l’identité individuelle des aînés séropositifs.

Mots clés : métaphores, VIH, aînés, personnes vieillissantes, enquête narrative

Context

Human immunodeficiency virus (HIV) and HIV-associated diseases have been known for three decades, and in that time many advances in care and treatment have been made. The advent of antiretroviral treatment in the 1990s and the success of highly active antiretroviral treatment (HAART) have enabled affected persons to survive to age 50 and beyond.

The impact of being HIV-positive on older populations is gaining new attention from researchers, public health organizations, and clinicians worldwide. This is in stark contrast to the situation only 10 years ago, when such older adults were an "overlooked" and "forgotten" population (Whipple & Scura, 1996). "Older adult" has been defined as a person age 50 or over by the Centers for Disease Control and Prevention: AIDS (Kirk & Goetz, 2009). By 2015 approximately half of adults with HIV in the United States will be 50 or older (Kirk & Goetz, 2009; Patel & Crane, 2011). The increasing prevalence of persons 50 to 59 with HIV infection is expected to grow: those with HIV are experiencing longevity, and the number of new HIV infections in those over 50 is increasing (Centers for Disease Control and Prevention, 2008).

These numbers have led to a shift from the conception of an HIV diagnosis as imminently life-threatening to an emerging conception of HIV as a chronic but manageable disease ("B.C. Centre for Excellence," 2012). Yet this view may be misleading as extended life expectancy makes aging with HIV a relatively new phenomenon, the implications of which are only now emerging. Medications may increase longevity, but aging with HIV can be unpredictable and challenging. Those aging with HIV experience the infection as a complex chronic disease with significant comorbidities (Patel & Crane, 2011) and an ongoing sense of life threat. Although life expectancy has improved, persons living with HIV/AIDS have increasingly complex needs as the immune compromization and associated stigma and discrimination may affect their emotional and physical health, quality of life, financial status, and independence (Public Health Agency of Canada [PHAC], 2012). More specifically, Eisenberger, Jarcho, Lieberman, and Naliboff (2006) found that individuals who experienced social rejection reported more social distress and physical pain. While HAART helps reduce viral load, these medications can produce hypertension, dyslipidemia, and insulin resistance (Heath et al., 2001) and can foster cognitive decline (Vance & Burrage, 2006). There is also a recognition of disease-related clinical concerns, such as increased cardiovascular risk, HIV wasting, and HIV-associated immune activation (Falutz, Hardy, & Kotler, 2010). Dognin and Selwyn (2010) report a recent HAART-era trend in the United States of concurrent HIV and cancer. Unique to the older adult with HIV is that, in addition to bodily changes resulting from the infection and the medications, are the layered aspects of the normal aging processes.

This has brought a new crisis: the "Greying of AIDS" (Gough & Karapita, 2011), or the "Greying Epidemic" (Berry, 2009). The day-to-day experiences, realities, and challenges of affected individuals remain largely misunderstood or invisible, and for this reason it is important that their stories be illuminated. To "story" is to "language" and give voice to, and when a person gives voice there is an opportunity to make sense and meaning of their experience, to cope, and to be as well as possible while living with illness. The language we use and how we speak about HIV and aging needs attention and intention if we are to better understand and support those living this new reality.

Introduction

The complex figure of speech known as the metaphor has been described as a "device of the poetic imagination and the rhetorical flourish — a matter of the extraordinary" (Lakoff & Johnson, 1980, p. 3). As one of four master tropes, along with metonymy, synecdoche, and irony, the metaphor is created when "two different and disparate subject matters are mingled to rich and unpredictable effect" (*Stanford Encyclopedia of Philosophy;* http://plato.stanford.edu/entries/metaphor/). An example can be found in Shakespeare's *Romeo and Juliet* (2.2.2–3): "But soft! What light through yonder window breaks? It is the east and Juliet is the sun." Metaphors help create meaning as ideas embedded in and conveyed through them arise from our world and reflect beliefs and values; they create expectations, influence decisions, and are a powerful way to increase understanding of things and processes (Geary, 2009). While metaphors help us make sense of our world, they can also be ironic and paradoxical tricksters in that they act as symbolic shorthand and as a way to *not* say precisely what we mean. The way that a metaphor analogizes or likens one subject to another (e.g., Juliet and the sun) is important and tenuous within illness experiences, as the most effective metaphors often compare two unalike things and we soon come to speak of and think of the secondary thing as if it were the primary. For example, we may initially think of disease or a virus as the enemy — "she is fighting cancer" (Lakoff & Johnson, 1994) — and then come to think of and treat a person living with a particular virus in the same way, as if she is under attack or is a valiant combatant heading into battle. Caution is required, as linkages made between two subjects — in this case, cancer and war — reveal one aspect of the subject explicitly, while other aspects remain implicit or concealed. Because they are so powerful, metaphors can hurt, hinder, or mislead when taken for granted, such that they blanket the particular and can flatten the very idea that is being conveyed.

Metaphors can also be generative, be playful, and inspire change for the good. They have the ability to evoke what can be described as an aesthetic way of knowing, as the trope creatively links two unrelated objects in a new and different way. Aesthetic knowing in nursing, initially conceptualized as knowing through the senses (Carper, 1978), is referred to here in an expanded way, as a dynamic pathway of knowing nursing through a relational interaction that reflects the art of nursing (Boykin, Parker, & Schoenhofer, 1994). By stimulating thoughts and imagination, metaphors can impact how we perceive the world and ourselves in it, in the present moment and in the next moment of our lives. Many authors describe the magic that can result when two unalike objects are likened. Baldick (1990) emphasizes the new combination of ideas to create more powerful understandings, Geary (2009) refers to the element of "combinatory play," and Janesick (1994) speaks of how metaphor de-familiarizes the familiar as it "creeps up on you and surprises" (p. 209). For Patton (1990), metaphor is an effective rhetorical tool that helps a researcher describe complex experiences in an evocative way. Rorty (1979) speaks of the imaginative power of metaphor and challenges current thinking by suggesting that if we go beyond representation and seek new ideas, new metaphors, and new language, this will help with intellectual and moral progress. Scholars such as Barry and Purnell (2008), Gaydos (2005), Greenwood and Bonner (2008), and Watson (1999) point to the important role of metaphor across nursing. Malinski (2009) echoes the view that the metaphor has transformative potential: "change your metaphor of the world, change your worldview" (p. 310).

The intricate relationship between metaphor and illness is explored in Sontag's (1978) classic, *Illness as Metaphor*. Sontag describes how metaphors for cancer and tuberculosis can ostracize, objectify, and produce an oppositional us/them mentality. In a later work (Sontag, 1989), her critique is expanded to include metaphors for AIDS, as will be discussed shortly. Yet because language is inherently metaphorical and only approximates embodied experience, scholars such as Biro (2010) posit that persons living with chronic illness and pain *must* use metaphors as a way to understand and talk about their illness experience. Frank (2011) agrees that metaphors are critical in stories of illness, especially chronic illness, where the experience is not linear or neat but most often complex and surreal, where "narratives have a problem with endings" (p. 189) and metaphors offer "expressive possibility" (p. 182). For the listener, paying attention to metaphors in illness narratives helps open up many possibilities of interpretation and thus ensures that he or she does not presume to know an individual or what it is they are experiencing.

For the teller of the narrative, the language serves to reveal, but they also may learn for themselves who they are, even if they might be unsure. We draw on the words of Jan Zwicky (2003) to illustrate this idea:

> The experience of struggling with illness is the experience of the fundamentally metaphorical nature of self: one is, and one is not, one's body. Music can also teach this: but it teaches it as harmony, not paradox. In illness, we grasp how the self approaches the condition of language. Compassion for the self: the most difficult language. (p. 35)

This deep-rooted influence of language in illness is found in metaphors associated with living with HIV, where our focus now shifts.

Literature Review

HIV-related metaphors permeate the literature and are seen as influential and disturbing. Sontag (1989) describes the metaphors used for HIV/AIDS as invasion, pollution, contamination and mutation, punishment, retribution, a plague, a death sentence, and "hard death." She describes how AIDS has been used politically: a metaphor for terrorism and international political evil. Her concerns resonate some 25 years later as many countries opt for a criminal view of HIV illness. The crime of "exposure without disclosure" results in charges such as assault, aggravated sexual assault, criminal negligence causing bodily harm, and attempted murder. This metaphoric likening of persons with HIV to violent criminals reinforces stigma, fosters the view of persons with HIV as bad, undesirable members of society, and raises complex public health and human rights concerns (Canadian Association of Nurses in HIV/AIDS Care, n.d.).

Hillmer (2007) found frequent use of the phrase "illness is warfare" in texts describing how the immune system functions in HIV/AIDS. Hillmer concurs with Sontag (1989) that such metaphors are dangerous, "encouraging strong drugs and surgery without heed to side effects, focusing attention on the disease rather than the patient, and leading to unnecessarily frightening images" (2007, p. 30). Others have explored HIV/AIDS as a broken narrative and as silence (Drakos, 2008). Lather and Smithies (1997) cite the metaphors "leper" and "demon" used to describe a person with HIV/AIDS. Mooney (2005) refers to the AIDS discourse itself as an epidemic. In a more positive light, Gosselink and Myllykangas (2007) examined leisure behaviours of older women with HIV/AIDS and found that each woman showed resilience in overcoming barriers and came to see leisure as a metaphor for the meaning of life. Jones (2002) studied the experience of HIV-positive nurses aged 28 to 52 and found the metaphor "double-edged sword" to represent the benefits and disadvantages of taking HIV medications. A year later she studied 10 adults aged 35 to 58 taking HAART, and found the metaphor "a bitter pill to swallow" (Jones, 2003).

Metaphors for HIV, whether harmful or helpful, impact how an individual tells about and lives the illness experience. They convey how the illness of HIV is influenced and socially constructed by fear and ignorance. A focus on HIV illness through the lens of warfare emphasizes the aggressive aspects of the disease and generates fear while keeping lesser-understood aspects hidden. Metaphors that instil fear can lead to discriminatory behaviours. Vance, Brennan, Enah, Smith, and Kaur (2011) found that adults aging with HIV face adversity and stigma. This population also faces depression (Jang, Anderson, & Mentes, 2011), social withdrawal (Vance & Burrage, 2006), and a need to negotiate secrecy. This is a concern. A study by Lourdes et al. (2008) found that while the prevalence of HIV in older adults is increasing, sexually active older adults with HIV may be engaging in high-risk behaviours for transmission and that perceived stigma is associated with inconsistent condom use.

There is a small body of literature emerging related to aging with chronic life-threatening illness and the role of metaphors. Metaphors analogize aging as a negotiation between decline and progress (Hammond, Teucher, Duggleby, & Thomaset, 2012), as contrasting the "sinful decay" of illness and aging as "romantic" (McCallum, 2001), as resilience (Clark, Burbank, Greene, Owens, & Riebe, 2011), as frailty and deterioration, and as a journey, fulfilment, and renewal (Kenyon, Birren, & Schroots, 1991). Pervasive Western views of aging tend to add a layer of stigma and oppression; they fail to capture the complexity in individual lives while perpetuating a culture of ageism that further devalues and distances us from aging and old bodies (Calasanti, 2005). Metaphoric language reveals an even stronger link to stigma for those with HIV. For adults who are living with HIV and aging, we do not fully understand what metaphors arise, how stigma may or may not present, or whether the stigma is unique to HIV or a reflection of aging in general.

Aging with HIV is a new area of concern and, in this new millennium, nurses are being called upon to support and care for greater numbers of HIV-positive older adults. As we gain more understanding of the experience as lived, we will be better able to provide meaningful and high-quality care. This timely study addresses three questions: *How are metaphors for aging with HIV experienced? What do these metaphors reveal? What might nurses learn from metaphors embedded in stories of older adults living and aging with HIV?* This focus on the power and use of metaphors within stories of living with HIV will add to nursing knowledge by providing access to the narratives of individuals who live at the margins and are not heard, thus generating insight into and understanding of the experience and illuminating social facets of living with HIV that metaphors reveal, and by illustrating the potential of narratives and "storying" in the nursing relationship.

Method

Narrative inquiry (Riessman, 2008), framed within social constructionist theory, was used to engage participants in the co-construction of stories about their experience of aging with HIV. Four commonly accepted concepts within narrative guided our approach. The first was meaning-making, the belief that stories hold meaning (Kleinman, 1988) and that storytelling generates sense-making and identity (Riessman, 2008); Josselson (2011) refers to stories as "the core meaning-making systems of real people" (p. 33). The second concept was close study of the "particular" within individual stories as a means to illuminate universals in human experience (Charon, 2006; Riessman, 2008). The third underpinning concept was social constructionism, the belief that the teller and the listener of a story influence one another such that meaning is co-created and co-constructed by them (Crotty, 1998). Stories and the language within are seen as a complex representation containing plural voices from one's social and cultural environment. This powerful interplay between individual meaning-making and the social world influences, shapes, and constructs how individuals make sense of everyday experience. The fourth interrelated concept that guided our approach was a belief in the role of metaphoric language within stories as a way to reflect influences and understand and talk about one's illness experience (Biro, 2010; Frank, 2011). Guided by these beliefs, we synthesized raw data from the participants' stories to capture aspects of the experience in their own words.

Sample

The study involved five Caucasian urban participants, three male and two female. Participants were 50 or older and living with HIV for at least 10 years. Two had been diagnosed with AIDS in the past. At the time of the final interview, participants were 55 to 62 (average 58.2). Number of years since diagnosis ranged from 13 to 24 (average 17.6). The participants were part of a purposive convenience sample of 32 adults recruited for a broader study on the narratives of life-threatening illness (www.uvic.ca/illnessnarratives). All five consented to have their data used for secondary analysis and to participate in an additional interview focused on aging. This allowed for more in-depth access to the experiences of aging with HIV across time.

All aspects of the study were approved by a university human research ethics board.

Data Collection

A semi-structured, in-depth approach was used to interview participants five times over a period of 3.5 years, except for one male who chose to be interviewed three times over that period. Each face-to-face interview was conducted by a nurse in the role of research assistant, who began by saying, "Tell me about your experience of living with HIV." The interviewer referred to an interview guide of gentle probes such as *Tell me more. What was that like for you?* and C*an you give me an example?* These prompts were seamlessly posed in a conversational exchange that was relational and discursive and intended to generate detailed accounts (Riessman, 2008). The first interview focused on building rapport and eliciting the participant's story of living with illness in whatever way that unfolded. In the second and third interviews the interviewer confirmed what was heard previously, posed exploratory questions to understand in more depth, and asked about new developments. The fourth interview was an opportunity to reflect on the interviews to date and the final one focused on the experience of living with HIV past the age of 50. The interviews varied in length from 1.5 to 3 hours and were audiorecorded. The generated narratives were transcribed verbatim.

Immediately following each interview, the interviewer audiorecorded spontaneous reflections on and impressions of the exchange, describing non-verbal communication, the physical environment, and the emotional energy. These recordings, which were transcribed as field notes, informed and added depth to the analytical process by illuminating context and affording our research team a way to reflexively examine our own assumptions.

Data Analysis

We followed a case-centred approach to narrative inquiry that emphasizes individual agency, particularities, and context (Riessman, 2008). "Case" is understood as a participant's narratives that, once transcribed, form the unit of analysis. This approach entailed close analysis of each participant's narratives to identify metaphors embedded within stories. Metaphors were not always evident, and the researchers read each participant's set of transcripts closely and repeatedly. The primary researcher (first author) identified metaphors used by each participant, then synthesized them into a short descriptive narrative, all the while conferring with the other researchers to validate identified metaphors. We returned to the transcripts and field notes repeatedly as a way to continually inform this iterative consolidation process. The research team then shifted the analysis to the sets of transcripts across the five cases and generated an overarching metaphor of "sunshine and shadows." Analysis involved finding a balance between description and interpretation.

Findings

The narratives were rich in metaphor as participants drew upon analogy as a way to express self and describe the reality of their experience across many areas of their lives, from diagnosis and treatment to experiences of death and loss, depression, secrecy, altered identity, and adapting to the life journey itself. We wove the metaphors used by each participant into a small story as a means of illustrating the findings. Each story, then, is a synthesis of the participant's words constructed by the researchers. The dense metaphors within each story help illuminate the many aspects of what it is like to age with HIV. Given that metaphors often slip into language undetected, we invite the reader to engage with the stories slowly, paying attention to and reflecting on the variety and depth of metaphors used, what they might reveal or conceal, and how a particular metaphor may evoke, in the reader, a connection or deeper understanding.

Aging With HIV: A candle flame dancing to the music of life
(Nancy, age 58, positive for 24 years)

> *The day I was diagnosed, my life took a turn. It hit me in the stomach. I went home and climbed into bed waiting to die. HIV is chaos; it is to lose your way and walk on unknown land with nasty pitfalls until you get your feet back on the ground. HIV is loss of innocence; it sits within me as tightness, down here, and is with me every day, a backpack I cannot put down unless I find safe ground. It is to live halfway between A and B — I'm not really healthy and not really sick. I have memories of walking in candlelight vigils in the '80s with people throwing things at me, as if stoning us. Even after 24 years, I feel the stigma and fear and humiliation. HIV erodes my confidence. For safety, I disclose that I am positive only when I'm in a group or with a witness. To be age 58 with HIV is a lonely place; I'm cut off from sexual relationships and the threat of being called a criminal is very real. And yet these are bonus years: I have survivor energy and love. My lessons learned are abundant, lessons about global compassion. I believe in this world; we are each other, we are one. And in the face of the challenges I have with aging with HIV, at times I am a phoenix rising from the ashes, reborn. I am dancing as fast as I can to the music of life, my best dance.*

Aging With HIV: A yo-yo of life lessons
(Judy, age 60, positive for 20 years)

> *HIV is a changed death equation. For me it was a death sentence when I was diagnosed; now it's a yo-yo — I'm unsure if I'm dying or not. My plot and stone are paid for and ready. I adhere to my medication regime because the pills take care of the HIV, they save me, although they are not*

> *a cure, you don't get your life back. The cocktail is hope, but I can't trust how long this family of meds will work. The meds are a life raft and I am a guinea pig being experimented on. For me, HIV is fatigue. I often lie on the couch and feel useless. I have a bug in my blood, living, trying to kill me, although there is less in me now. HIV is a reminder for me from the universe to pay attention and be thankful. I see myself as no different from anyone else my age; we all deal with challenges. HIV has become a smaller part of my life, and yet to age with HIV for me is to live with fear and sometimes panic; I live with a secret that is not coming out for fear of stigma by my non-HIV contemporaries who will judge me as having the naughty disease, the dirty disease associated with sluts, drugs, and prostitutes. And yet I feel lucky to be on disability and live in a subsidized home, a place I have created over 20 years and where I belong, but it is contingent on keeping my HIV a secret. I live with fear but I keep blooming, like my plant; it is to volunteer at a local HIV agency and feel safe there, to be out about my status, where I do my turn, have a sense of purpose and feel needed. At age 60, HIV is about being the expert, about doing my own inner work even as the old tapes keep playing over and over, about self-forgiveness and about the mind, body, and spirit coming together. To tell my stupid, sad story is cleansing, like cleaning out a closet; it's the easiest story to tell, of lessons learned on the road.*

Aging With HIV: Rainbows, confetti, and tea and cakes

(Leonard, age 62, positive for 18 years)

> *Diagnosis: 2 years to death. Terminal. I saw the box on the assessment form ticked off. I face depression: a horrible dark place, filled with stigma and pain; it makes me a leper on the precipice, and is more difficult than HIV. I have attempted suicide, a turning point, rock bottom. I have come out of the closet three times: being gay, having mental illness, and having HIV. HIV owned me, a tattoo. BIG. It was number one on my Rolodex list of things to worry about. HIV is pain buried in a very deep, dark place. HIV is pity, ignorance, hurt, name-calling (fag, queer), and hiding (in the closet). For me, it has been secrets, little pieces of information that owned me, that kept germinating. It was stigma that made walls go up, made everything bigger than the earth. It was living on the edge, hard, fast, being self-destructive in a new world I didn't know how to enter. Living positive for 18 years has changed how I experience HIV. Now, HIV is no secret. To tell is to let it go down to little bits, to look people in the eye and see your soul and not deceit — it is to be the face of HIV, to make it mundane like tea and cakes. To age with HIV is to be a mentor, a substitute father, an uncle, a sage, a societal elder, a gay grandpa, a less intimidating member of society. Everyone smiles at me! It is a time of my third*

> *act, of self-strength and wisdom, of getting rid of material things. It is to age gracefully, to be privileged, eccentric, to no longer mould to societal norms, to be thankful for the HIV as a blessing, a gift. To enjoy bonus years and see myself as a long-time survivor. To live normally, a rebirth, to live a balanced life in sync with the planet, to not fight it but accept a natural order to life. HIV is about volunteering and giving back, being useful, helping others; it is kindness first. To volunteer at the local HIV agency is like coming home, my place, my rock, no tippy-toeing, a starting place for who I am and not an end point. I am at the bookends of my life, my story has no ending; telling my story is a mirror of my own thoughts and the truth will set you free.*

Aging With HIV: A rollercoaster ride with face into the wind

(Rick, age 56, positive for 13 years)

> *Memories of the 1980s are painful for me, fresh and easily retrieved. I recall living in Vancouver's West End: ground zero, an emergency, trench lines, ugly, terrifying paranoia, five pages of friends who died, full of ghosts. It was going through the wars with friends, evictions, short-term death sentences, overdoses, obsessions with meds, blurred faces on ads, secrecy, and anonymous testing. Today, aging with HIV for me is about following a drug regime; it's a numbers game, like the stock market, the numbers up, down, on edge, the trend, the downward slope, the steady rise, the high, the blip. My numbers are currently high, high, high, phenomenal, triple digits. I'm on my fourth cocktail and talk of the fifth is like looming death. My options are decreasing. HIV is not chronic illness; you take the harsh chemicals, you strike a bargain and have a responsibility to take the regime, you play the hand you are dealt. I feel lucky, pure dumb luck, in balance despite side effects. I have taken the mask off and become a face of HIV, no veneer, no more secrets; I come out of the HIV closet to everyone. There's a freedom in being totally open and upfront, to not care, to belong to the gay and positive community, to a family of choice, to have a circle of friends, and to be part of my local neighbourhood. I live the lesson that we are all part of one community, part of the mix. For me now, it's a different world, to live with an attitude of survival, to feel settled, confident, and in balance. I volunteer at the local HIV agency in ways that do not put my hurt on the line. It is to be on a life journey, facing forks in the road, making decisions about retirement and downsizing my home with my partner, reinventing myself and having my life go forward. To age with HIV is also to have money issues and enter a new level of poverty. There is no "Freedom 55"; stress means I'm dancing as fast as I can at times, still facing a black well of depression at times, like being on a rollercoaster, rocketing around; so many layers to the onion. Post-traumatic stress is ever*

> *present, yet I'm a survivor, I put one foot in front of the other. And this aging is a time of beauty. I have all these years of experience and knowledge that take me forward.*

Aging With HIV: A lab rat on a running wheel

(Norm, age 55, positive for 13 years)

> *My experience of aging with HIV is medications: a double-barrelled shotgun. I know the meds are miraculous and life-giving, yet I push the envelope, can't trust them, an awful bunch of stuff, toxic and brutal. To age with HIV is to be a lab rat on my own. You step your way through it. I refuse to follow the party line, to swallow the bitter pill. I know there's an instruction manual but prefer to read between the lines. I know if I don't take them I'm dead. But let me be clear: they are not vitamins; they make me sick as a dog. I make a lousy patient, a long-term patient. It's a balancing act, I walk a fine line. HIV is living by the numbers of my blood work; I fool around with the numbers, my CD4 count, viral count, WBC. For me, there's uncertainty about the future; the future doesn't exist. I live in the moment, in the present, on a different plane from my friends. I'm apart from other people. I live outside the box and don't sweat the small stuff, the everyday bullshit. Stigma is real. I face everyday ignorance in the form of comments that suggest I'm on meds and therefore cured! That I should be grateful to be alive, or if I am sick why don't I look like Tom Hanks in* Philadelphia*? So I pick and choose who I spill the beans to, protect myself. HIV is to live two roles, a public and a private. I wear a tattoo, a brand, a pox on my name. HIV is to hide a secret, to pretend, to lie, to be a spy and not blow my cover. It is to live behind a façade and act as if all is okay, to hide behind a cover of happiness, to put on a good face. I am a pariah, an untouchable. I face depression, what I call a grey zone and a black zone. The journey has been one of difficulty, a big, long road, a grind. I'm frustrated, keeping the inner turmoil inside, turning inward, insular, cutting myself off, being a loner. To age with HIV is a life sentence, a constant struggle, a fight. I have fought back from AIDS and have a guardian angel with me; it's not my time. I'm older and I'm a survivor and the key to it all is my cat, my best friend, my spirit animal companion, a quiet private innocent just like me.*

Discussion

Our participants used metaphor as a device to help them "language" the experience of their complex lives, and to "language" or give voice to something can help one make sense of it and understand it (Johnson & Lakoff, 1980). Associations made through metaphor were subtle at times and not so subtle at other times. Some metaphors had the capacity to support living well, while others remained as stark reminders of associations made through metaphor that can hurt, cause rejection, and foster stigma and discrimination.

Each metaphor reveals and can be considered a small personal and profound story unto itself. Metaphors, as social constructions, offer a way to see how knowledge is constructed through everyday language (Crotty, 1998). Through their influence, metaphors have the ability to shape, constrain, expose, liberate, or illuminate how one experiences a disease. In this research, metaphors within stories of older adults aging with HIV illuminate how having the "bonus" of added time and life experience impacts day-to-day living and the challenges of living beyond life expectancy.

Participants' metaphors reveal the experience of aging with HIV to be one of living between dichotomous tensions such as sadness and joy, darkness and light. The fluid and non-linear nature of these tensions makes life fragile. For most participants, aging afforded a shift in the tensions and an evolution towards sense-making and reconciliation as they, as older adults, drew upon rich life experiences and adapted as best they could to living in transitional spaces. Unique metaphors for individual participants reflect this: a candle flame that burns brightly but is fragile and needs protection; life lessons that hang by a tattered string, going back and forth, like a yo-yo, between secretiveness and openness; a rainbow life attitude following years of a harsh storm, a time when old secrets fall away like confetti and aging with HIV is as normal as having tea and cakes; a rollercoaster ride with twists, turns, and fear but also joy and freedom that feels like fresh air upon an unmasked face; and a laboratory rat, trapped, going on and off medications, feeling unwell and dizzy yet unable to find firm ground. These metaphors support and extend findings reported elsewhere on experiences of living with HIV (Jones, 2002, 2003) and yet differ in degree within the context of aging.

The metaphors reveal that to age with HIV is to live and struggle in the inescapable shadow of disease over time. The availability of HAART, extended years, and the move to HIV being considered a chronic disease were unthinkable at the time of diagnosis; yet these achievements have not erased the real and raw hurt, fear, secrets, and the need to gauge truth-telling that stigma generates. For some, the metaphors are extreme and embodied; an older adult may take on the identity found in a social metaphor such that they begin to see themselves as viewed as tattooed, untouchable, or having a dirty disease (Mooney, 2005). Consequently, some have, over time, developed coping strategies such as taking off their mask, telling everyone they meet about their HIV status, and eventually being proud to be a face of HIV. Tension lies in living between the desire to be free of secrets and live with honesty and the underlying uncertainty about the safety of disclosing.

All have faced the reality of continual, cumulative loss and death, in particular the harshness of dying with AIDS, and now live with hope tempered by tension and uncertainty, wanting to take the drugs in order to live yet knowing these are toxic, trusting their cocktail will continue to be effective yet knowing its effectiveness may end, wanting to live in the moment yet anticipating an early death. These tensions exist within social contexts of living with few resources, sometimes in poverty, with uncertain access to community supports; the dance of aspiring to live in the moment and apply life lessons learned, to adopt an attitude of gratitude, to have a sense of a gift and being lucky, and yet knowing it is all tenuous as the attitudes of others and inner depression can upset the fragile balance at any time. Metaphors also provide insight into a sense of belonging, of having arrived at a place, or a sense of community, this being quite solid for some and under threat for others. There are expressions of the beauty and joy of aging, of embracing new roles such as that of long-time survivor and elder or uncle; these identities help counter negative social attitudes while also generating a sense of seeing self as seen, as reconciling who they are now as less threatening older adults.

As a result of major antiretroviral advances, an increasing number of people with HIV are living into older adulthood ("B.C. Centre for Excellence," 2012). Findings from this study deepen our understanding of experiences of this emerging phenomenon.

The research team also engaged the imagination with in-depth knowing across the group to arrive at an overarching metaphor that transcends the individual: shadows and sunshine. This metaphor allows for simultaneous tensions within experiences. The representation of shadows raises questions about the role of language in the construction of stigma. Aging survivors of HIV in the Western social context feel the cool, dark shadow of what we will call omnipresent *S* factors: harsh and harmful social factors that slip in and salt a wound, such as stigma and stereotypes, but also secrets, shame, slurs, stupidity, struggle, stress, side effects, suicidal thoughts, sorrow, spiralling, and being stuck. The breadth and depth of this dark side is unique to HIV conceptualized as a chronic illness, and is emphasized with the passage of many years. The dual aspect of sunshine holds light and joy, helpful, healing *S* factors such as sense of safety, support, self-assuredness, successful strategies, and soul-searching. Each of these factors has the power to ever so easily tip the personal experience from a high to a despairing darkness that affects well-being.

The metaphors identified in this study contribute to a growing scholarship (Barry & Purnell, 2008; Biro, 2010; Frank, 2011; Malinski, 2009) that illustrates how metaphors can help us understand the tenuous experience of another.

Nursing Implications

An awareness of metaphors and how they function in stories can deepen one's understanding of the complex experience of aging with HIV and thereby enrich nurses' ability to be supportive, compassionate, and effective. Metaphors help communicate and make aspects of experience more visible and recognizable, allowing us to hear and interact with them, possibly to be humbled and to move closer to understanding another's life experience that we can never truly know. The insights and understanding that nurses can glean from listening for and inquiring about metaphors embedded in the stories of those aging with HIV can have far-reaching implications. Understanding an individual's unique reality invites sensitivity and compassion into one's nursing approach, which in turn supports the timely, effective, and person-centred tailoring of care and services. Nurses are called upon to cultivate curiosity and solicit stories about everyday life experience, to create spaces to ask *What is this like for you?* and then listen with an acute ear, an open, non-judgemental attitude, and an attentiveness to language that helps reveal — in essence, to bear witness. To ask about a metaphor that arises in conversation and check interpretations with the person may uncover further meaning, self-understanding, or socially constructed challenges of aging with HIV, such as poverty and stigma, that metaphors help express. Once communicated, these can be addressed as appropriate. It is important that nurses take the role of stigma into account, given that it may adversely affect health (PHAC, 2012), social ease, and ratings of pain (Eisenberger et al., 2006). The presence of stigma makes aging with HIV different from aging with chronic conditions that do not carry the same negative associations.

Nurses must also pay attention to metaphors that they themselves may be using and be aware of how certain words can serve to silence or adversely influence the person before them. This "aesthetic" way of knowing, which illuminates the art of nursing and perceptual sensibilities (Boykin et al., 1994), also offers a way into conversations that build insight and illuminate the challenges, beliefs, hopes, fears, and sense of identity that may not be easily expressed but that are part of living and aging with HIV every day. Informed understanding leads the way for nurses to feel confident about providing, and able to provide, a genuine presence and the support needed to promote access to resources and care.

Conclusion

A diagnosis of HIV changes everything, forever. The force of its rupture follows one through life into older adulthood. To age with HIV is to live with shadows and sunshine, to live between myriad fluid tensions associated with the disease and its treatment, aging, and the social context of stigma. To age with HIV is to shift closer to a balance and a reconciled sense of identity and belonging, although this is ever tenuous and variable and is unique to each person. When nurses listen for and understand metaphors embedded in stories, they can more fully support older adults in facing shadows and letting in the light.

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CJNR 2014, Vol. 46 Nº 3, 26–45

A Scoping Review of the Literature on Internationally Educated Nurses in Canada: Mapping a Research Agenda

Christine L. Covell, Elena Neiterman, Ivy Lynn Bourgeault

The purpose of this scoping review was to map key themes in the Canadian literature on the professional integration of internationally educated nurses (IENs), identify the types and sources of and gaps in evidence, and offer recommendations for research. The work was guided by a 6-step methodological framework for scoping reviews. The search and selection of academic and grey literature for the period 2000–13 resulted in a sample of 157 papers for full-text screening. Themes derived from the literature reflect stages of IENs' professional integration: pre-immigration and early arrival, professional recertification, workforce integration, and workplace integration. Data were extracted, coded, and collated using electronic charts. Numerical and qualitative thematic summaries were used to analyze the data. Recommendations for research are as follows: create data systems to track IEN immigration and integration; determine the effectiveness of programs and policies for IENs; and examine the influence of language proficiency on professional recertification, workplace integration, and patient safety.

Keywords: human resources, internationally educated nurses, integration, recertification, scoping review, Canada

Résumé

Une analyse exhaustive de la littérature canadienne portant sur le personnel infirmier formé à l'étranger : recensement des thèmes clés traités dans la recherche

Christine L. Covell, Elena Neiterman, Ivy Lynn Bourgeault

La présente analyse exhaustive a pour objectif de recenser les thèmes clés traités dans la documentation canadienne portant sur l'intégration professionnelle du personnel infirmier formé à l'étranger (PIFÉ), de déterminer les types et les sources des données probantes ainsi que les lacunes, et d'émettre des recommandations en matière de recherche. Dans le cadre de cette analyse, les auteures ont utilisé un cadre méthodologique comportant six étapes. Le recensement et la sélection d'une littérature didactique et d'une documentation parallèle couvrant la période de 2000 et 2013 a mené à un examen des textes intégraux de 157 documents de recherche. Les thèmes extraits de la littérature reflètent les étapes de l'intégration professionnelle des PIFÉ : la pré-immigration et l'arrivée au Canada; le recertification professionnelle; l'intégration au marché du travail; et l'intégration au travail. Des données ont été extraites, codées et rassemblées en utilisant des tableaux électroniques. Des résumés thématiques numériques et qualitatifs ont été utilisés pour analyser les données. Les recommandations en matière de recherche sont les suivantes : créer des systèmes de données pour suivre la démarche d'immigration et d'intégration du PIFÉ; déterminer l'efficacité des programmes et des politiques à l'intention des PIFÉ; et examiner l'influence de la maîtrise de la langue sur la recertification professionnelle, l'intégration au travail et la sécurité des patients.

Mots clés : personnel infirmier formé à l'étranger, intégration, maîtrise de la langue, recertification, analyse exhaustive, Canada

Despite reports of a growth in the supply of Canadian nurses (Canadian Nurses Association [CNA], 2013), forecasters estimate that by 2022 an additional 60,000 nurses will be required to meet the demand (Tomblin-Murphy et al., 2009). As a result, Canada continues to prioritize the selection of nurses for immigration (Government of Canada, 2014). Facilitating the professional integration of internationally educated nurses (IENs) is viewed as a key strategy for increasing Canada's ability to respond to the projected nursing shortages (Health Canada, 2010).

Currently, approximately 7.2% (25,656) of the Canadian regulated nursing workforce is internationally educated (Canadian Institute for Health Information, 2013). IENs from many countries with varied educational preparation and professional experience continue to migrate to Canada. Once in Canada, they settle in different areas of the country that have different requirements for registration and offer different levels of support to help them integrate into the nursing profession (Bourgeault, Neiterman, LeBrun, Viers, & Winkup, 2010). Differences in their nursing education and level of support are thought to explain why some IENs become regulated nurses while others experience serious difficulties and never integrate into the profession in Canada. In the absence of data systems to track the immigration and integration of IENs, it is impossible to determine the exact number of IENs who are not registered with a regulatory college and to explain why some are unable to practise in Canada. When IENs cannot practise nursing, Canada loses valuable health human resources (Kolawole, 2009).

Over the last decade considerable financial investment and policy development have been directed towards helping IENs meet the requirements for registration and secure employment as nurses (Health Canada, 2010). Consequently this scoping review is a timely and important addition to the literature. Its purpose is to map key themes in the Canadian literature on the professional integration of IENs, identify the types and sources of and gaps in evidence, and provide recommendations for research.

Methodology

Our work was guided by an updated version of Arksey and O'Malley's (2005) six-stage methodological framework for scoping reviews (Levac, Colquhoun, & O'Brien, 2010). Below, we present the process used to conduct our scoping review, describing each stage of the methodological framework.

Stage 1: Identifying the Research Questions

Since the purpose of a scoping review is to summarize a large amount of literature on a topic, the research questions are broad (Levac et al., 2010).

The research questions for our scoping review were as follows: *What types and sources of evidence are available for IENs in Canada? What is the focus of the conceptual and empirical literature on IENs in Canada? What are the gaps in evidence that can be addressed by research?*

Stage 2: Identifying the Academic and Grey Literature

To begin the literature identification process, we assembled a team of researchers who were experts in scoping review methodology and had extensive content experience in the area of IENs. We also formed an advisory council of IEN stakeholders: representatives from academia, federal and provincial/territorial government organizations, and professional regulatory colleges and nursing associations that work with or on behalf of IENs.

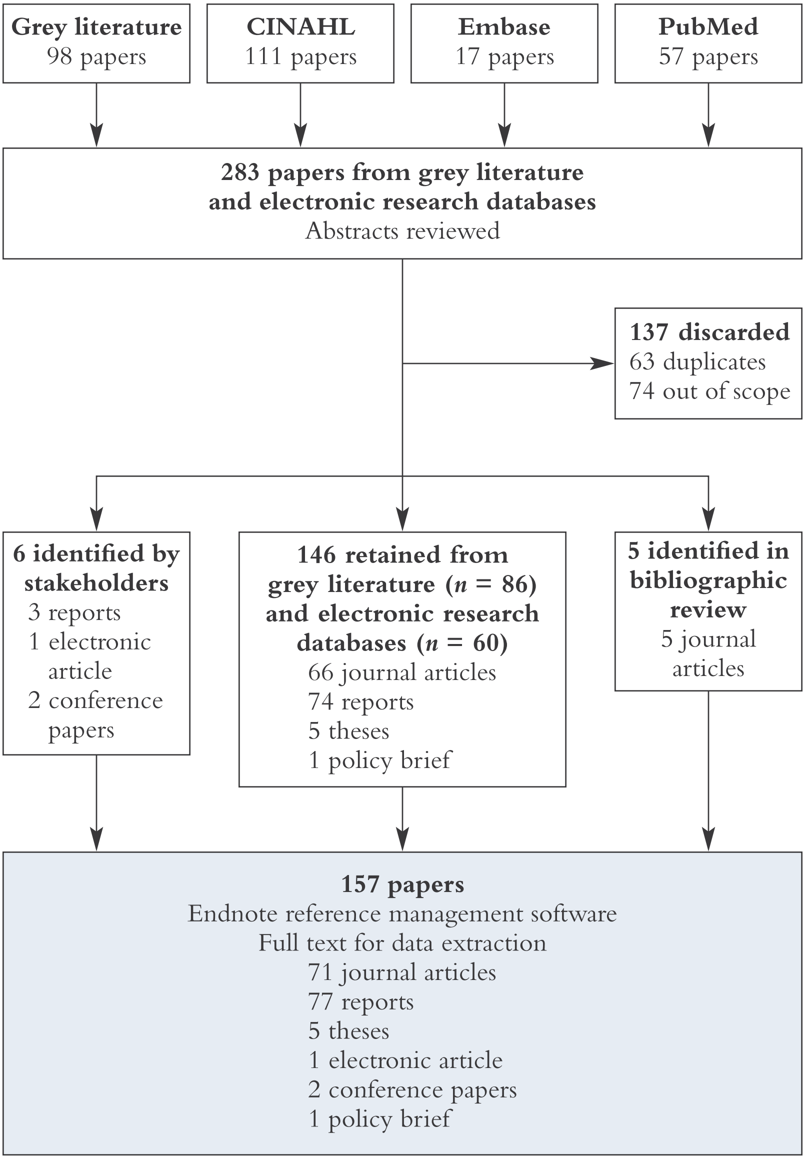
The inclusion criteria were as follows: papers issued from 2000 to 2013 inclusive, in the English or French language, about IENS in Canada. We excluded papers if they were outside the timeframe allotted for the review or if they were not about IENs in Canada.

To ensure comprehensiveness of the review, we used multiple strategies to locate both the academic and the grey literature. The academic literature was searched through the electronic databases CINAHL, Embase, and PubMed. The keywords used (alone and in combination) were "nurses," "health professionals," "internationally educated," "migrant," "foreign-trained," "immigrant," and "Canada." Using the same criteria, we searched the grey literature through the Canadian Electronic Library, the Canadian Health Human Resources Network library, and the Web sites of federal, provincial, and territorial governments and professional and immigrant associations. We conducted hand searches of the bibliographies of the identified literature. We also consulted our advisory council for further literature sources. The search produced a total of 283 papers.

Stage 3: Selecting the Literature

A systematic process was used to select the literature for our scoping review. We imported the search into a reference-management program and discarded 63 duplicate papers. The abstracts for the remaining 220 were screened by two members of our team to determine their relevance to the review's purpose and the research questions. This resulted in the discarding of 74 papers that were not about IENs in Canada or were outside the period covered in the review. Our bibliographic review produced five journal articles. The advisory council identified six additional literature sources. The remaining 157 papers were subjected to full-text screening. Figure 1 summarizes the literature search and selection.

Figure 1 *Academic and Grey Literature Search and Selection*



Stage 4: Extracting and Charting the Data

To ensure standardization of data extraction and charting across the team (Levac et al., 2010), we developed a charting tool in Microsoft Excel. The categories for data extraction reflected our research questions: type of paper (journal article, report, thesis, electronic article, conference paper, policy brief); if applicable, research method (qualitative, quantitative, mixed-method); geographic location (pan-Canadian, province or territory); and themes.

The themes were developed after each team member had carefully read and reread the literature. The priori template of major themes was developed to reflect the stages of professional integration: pre-immigration and early arrival, professional recertification, workforce integration, and workplace integration. As shown in Table 1, standard definitions were developed for each major theme. Minor themes were developed inductively and used to organize the information within each major theme. To ensure that the data-extraction process was reliable — that is, consistent with the research questions — each team member used the charting tool to independently extract data from 10 papers and the results were compared (Levac et al., 2010). Discrepancies in the coding were discussed by the team and the tool was refined before we proceeded with data extraction.

Table 1 *Themes*

Major Themes	**Definition**	**Minor Themes**
Pre-immigration and early arrival	The activities that IENs engage in prior to migration and upon arrival to prepare for practising their profession in Canada	▪ Push and pull factors ▪ Ethics of international recruitment ▪ Pre-arrival activities ▪ Early arrival programs
Professional recertification	The process that IENs engage in to meet the requirements for registration with a nursing regulatory college in Canada	▪ Credential verification and assessment ▪ Licensing examination ▪ Bridging programs ▪ Alternative types of employment as paths to professional recertification
Workforce integration	When IENs receive their licence to practise nursing and are employed as regulated nurses in Canada	▪ Barriers and facilitators
Workplace integration	When IENs become staff members of an organization where they can use their nursing knowledge and expertise	▪ Barriers and facilitators ▪ Racism and discrimination

Stage 5: Collating, Summarizing, and Reporting the Results

We collated the extracted data into numerical and qualitative thematic summaries. To address our research questions we used frequencies to report the numerical data. We reported qualitative data by summarizing it in narrative syntheses. We then analyzed our findings in relation to the purpose of the scoping review and identified gaps and areas for future research. In accordance with scoping review methodology, we did not appraise the quality of the literature (Grimshaw, 2010).

Stage 6: Consultation

The advisory council was consulted at three stages in the review. During the first stage they provided feedback on the research questions. During the third stage they made suggestions for additional literature. At the final consultation they provided feedback on the findings.

Findings

General information about the types and sources of evidence identified during the charting process is presented below, followed by the numerical and qualitative thematic analyses organized by major theme: pre-immigration and early arrival, professional recertification, workforce integration, and workplace integration. The gaps in evidence are highlighted within each theme.

Types and Sources of Evidence

Of the 157 selected papers, 148 were journal articles and reports issued by government agencies, professional associations, or nongovernmental organizations. The remaining nine were theses, electronic articles, conference papers, and a policy brief. The majority were produced by a national body or generated by authors from the province of Ontario. Approximately 22% of the papers (*n* = 34) were research studies, nearly all using descriptive qualitative methods, primarily semi-structured interviews. The remaining papers were non-empirical, such as commentaries/opinion pieces, evaluations of exploratory projects, or reports issued by professional associations.

IENs are defined in the literature as nurses who have migrated to Canada but whose basic nursing education was obtained in another country. The literature does not differentiate between IENs who enter as immigrants intending to permanently reside and work in Canada and those who are "holiday migrants" intending to work during a temporary stay in Canada. The literature does not explore how IENs' immigration status (e.g., permanent or temporary) or category (e.g., economic immigrant, family class, refugee, student) influences their intention to professionally recertify and practise their profession in Canada. Additionally, the literature does not differentiate IENs according to their academic preparation or nursing expertise.

Numerical analysis of the themes indicates that the literature focuses on the first two stages of IENs' professional integration (Figure 2). The pre-immigration and early arrival literature is concerned mainly with the ethics of international recruitment and strategies that IENs can use to prepare for migration. The professional certification literature concentrates on the barriers to verification and assessment of credentials and the strategies and programs available to address them.

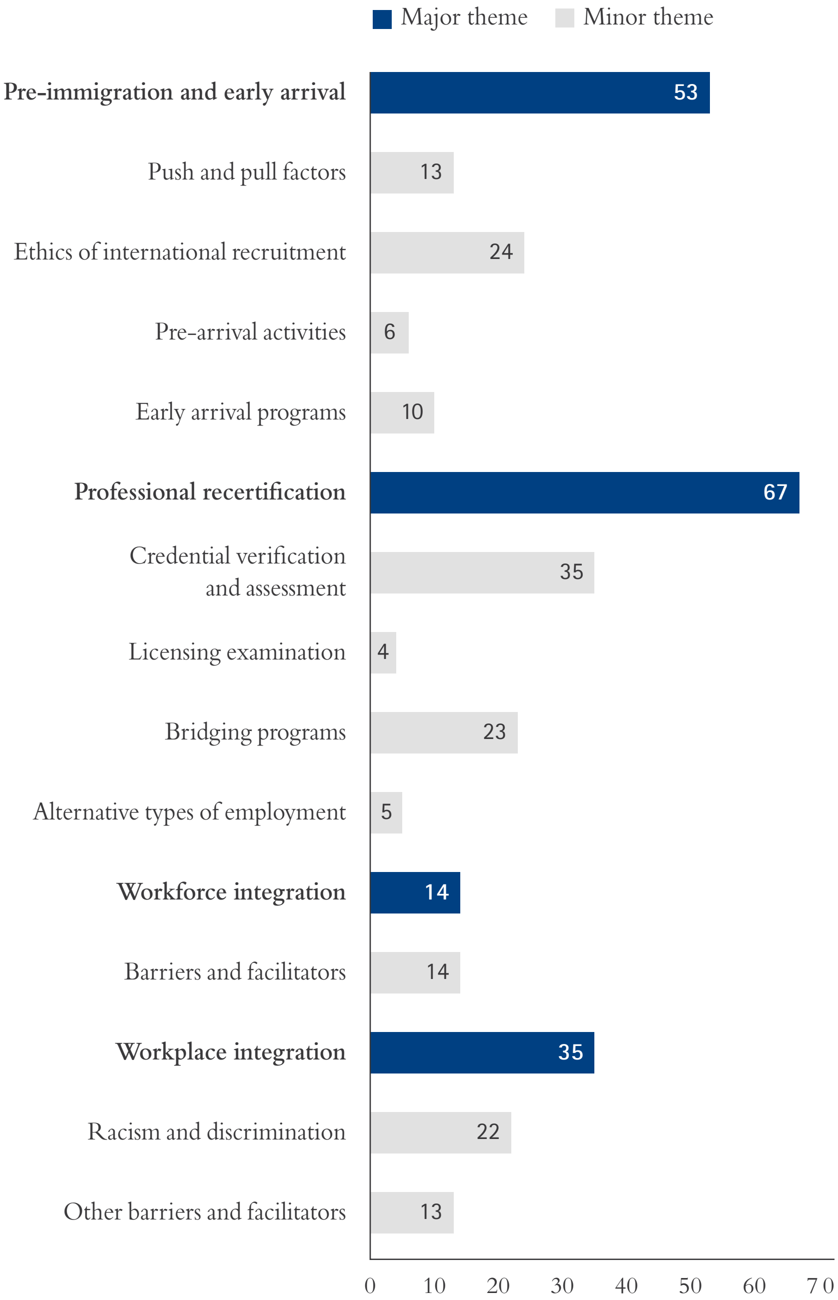
Pre-immigration and Early Arrival

The pre-immigration and early arrival literature reveals the minor themes of "push" and "pull" factors, the ethics of international recruitment, pre-arrival activities, and early arrival programs ($n = 53$). While largely focused on the ethics of international recruitment, it also discusses the factors that push and pull IENs to migrate to Canada, describes strategies that IENs can adopt prior to migration, and describes programs available to support IENs during the resettlement period.

Push and pull factors. Thirteen papers discuss the factors that contribute to IENs' decision to migrate. The factors that push IENs to leave their home country include broad political, financial, and/or social difficulties as well as professional issues such as lack of medical resources, poor working conditions, or low remuneration (Baldacchino & Saunders, 2010; Khaliq, Broyles, & Mwachofi, 2009; Ronquillo, Boschma, Wong, & Quiney, 2011). The factors that pull IENs to Canada are often personal, such as a better quality of life for their families and educational opportunities for their children (Blythe, Baumann, Rheaume, & McIntosh, 2009; Ronquillo et al., 2011). Professional factors such as ability to earn higher wages, advance their education, and develop their nursing expertise are recognized as those that pull IENs to Canada (Bourgeault et al., 2010; Khaliq et al., 2009). While the literature discusses push and pull factors, there is no evidence as to which factors are most or least important or how they interact with each other.

Ethics of international recruitment. The ethics of international recruitment is particularly salient in the literature ($n = 24$). Of concern is the impact of overseas recruitment on the nursing human resources of the sending countries and the likelihood of IENs recertifying as nurses once in Canada (McIntosh, Torgerson, & Klassen, 2007). The literature acknowledges that Canada does not actively recruit nurses at the national level; however, there are reports on the direct recruitment of IENs by private agencies and provincial/territorial or regional health authorities (Beaton & Walsh, 2010; Saskatchewan Registered Nurses Association

Figure 2 ***Frequency of Major and Minor Themes***



[SRNA], 2008). There is little formal literature describing direct recruitment initiatives or their influence on IENs' professional recertification or long-term employment.

Pre-arrival activities. The six papers on pre-arrival activities focus on strategies that IENs can use to expedite the credential verification process. These activities include gathering relevant documents, learning about the Canadian health-care system, writing the licensing examination, improving language skills, providing the regulatory college with evidence of language fluency, and, when necessary, having their clinical skills evaluated (Bassendowski & Petrucka, 2010; Singh & Sochan, 2010). If IENs require upgrading, locating the appropriate courses and making logistical and financial plans are additional measures they can take prior to migrating (Atack, Cruz, Maher, & Murphy, 2012). IENs who adopt these strategies seem to recertify more easily than those who begin the recertification process after arriving (Government of Canada, 2011). However, there is little evidence to support this observation.

Early arrival programs. Ten papers include information about early-arrival programs designed to provide IENs with assistance during the resettlement process. IEN advocacy groups and associations provide information, guidance, social support, and education (Western and Northern Health Human Resources Planning Forum, 2006). To address the financial barrier to registration, Human Resources and Skills Development Canada (HRSDC) introduced the Foreign Credential Recognition Loans Pilot to help internationally educated health professionals offset the cost of recertifying (HRSDC, 2010). With the support of HRSDC, several provinces and territories have set up micro-credit loan programs to assist newcomers with fees associated with recertification. The literature does not address the effectiveness of these programs.

Professional Recertification

The professional recertification literature includes the minor themes of credential verification and assessment, licensing examinations, bridging programs, and alternative types of employment as paths to recertification (n = 67). The literature focuses on the challenges that IENs face during the recertification process, such as getting their credentials verified and assessed and passing the licensing examination.

Credential verification and assessment. The first step in obtaining a professional licence in Canada is having one's credentials formally verified and assessed through a provincial nursing regulatory college. The 35 papers centred on the credential verification and assessment process describe the complications that can ensue if an IEN is unfamiliar with the Canadian accreditation system, lacks the necessary documentation, or does not know to which regulatory college the documents should be submitted. These barriers can be compounded if the IEN has poor language proficiency (Alberta Network of Immigrant Women [ANIW], 2005).

IENs use several strategies to obtain information about the credential verification and assessment process (Murphy, 2008). Many IENs report difficulty securing information about how to qualify for the licensing examination and the paperwork necessary to have their credentials verified and assessed (Sochan & Singh, 2007). To address these obstacles, regulatory colleges and governments across the country have established assessment centres and developed strategies to ensure that as many IENs as possible have access to timely and transparent verification and assessment (Cartmel, 2009; Turner, 2009). The competency assessments, such as the Prior Learning Assessment and Recognition developed by the College of Nurses of Ontario, are based on provincial entry-level competencies. They are designed to help the regulatory colleges determine whether an IEN meets the requirements for recertification (Belkhodja et al., 2009). There is little literature describing the outcomes of these initiatives.

Licensing examinations. Facilitation of IENs' successful performance on the Canadian Registered Nurses Examination (CRNE) is less evident in the literature, with only four papers specifically discussing this issue. The CRNE pass rate for IENs is 45% to 56% — well below the 87% average achieved by Canadian-educated nurses (CNA, 2013). Poor language proficiency is the most frequently cited reason for IENs failing the licensing examination (Newton, Pillay, & Higginbottom, 2012). This finding is supported by CNA statistics indicating that IENs from countries where nursing education is in English, such as the Philippines, consistently outperform those from non-English-speaking countries (CNA, 2013). Another reason why IENs have difficulty with the examination is cultural biases (Jeans, Hadley, & Green, 2005). On average, it takes IENs more than one attempt to pass the CRNE (Blythe & Baumann, 2009).

Quebec does not use the CRNE but instead administers a paper test and a practical session where nurses provide care to simulated patients. IENs in Quebec must participate in a bridging program and meet French-language requirements (Ordre des infirmières et infirmiers du Québec [OIIQ], 2014). Approximately 4% of nurses registered in Quebec are IENs (OIIQ, 2004).

The literature search did not locate information about IENs' performance on the Canadian Practical Nurse Registration Examination (CPNRE) or the Registered Psychiatric Nurses of Canada Examination (RPNCE). The reasons why IENs pursue licensing as registered practical nurses or registered psychiatric nurses are not well described in the literature.

Bridging programs. The literature includes 23 papers that discuss professional bridging programs in Canada. These programs have been established to address the various barriers to IENs' achieving recertification. In 2012 approximately 35 bridging programs were available for IENs in Canada (Canadian Association of Schools of Nursing, 2012). There are variations in models and curricula, and not all bridging programs include clinical placements. The literature offers various recommendations with respect to bridging programs. These include orientation to the Canadian health-care system (Baumann, Blythe, Rhéaume, & McIntosh, 2006), language assessment and instruction, and curricula to address theory and practice gaps specific to the Canadian context such as long-term care and psychiatry (Bard, 2009; McGuire & Murphy, 2005). Coffey (2006) recommends that bridging programs include curricula supporting the entry-to-practice Bachelor of Science degree now compulsory in most provinces.

Direct-to-work bridging programs have been developed to facilitate the integration of IENs who were recruited overseas to work in Canada (SRNA, 2008). Though the literature does not describe these programs fully, they are known to include clinical placements and to provide IENs with continuing support in the workplace. There is little evidence detailing the outcomes of these programs.

Less prevalent in the literature is information about including IENs in existing nurse refresher programs as a form of bridging. The literature does stress that nurse refresher curricula are designed specifically for Canadian-educated nurses who have been out of the workforce. Since Canadian-educated nurses participate in nurse refresher courses to update their knowledge and skills when returning to the workforce, these courses are not designed to meet the needs of IENs (ANIW, 2005). Nonetheless, some IENs have found it beneficial to attend, especially when bridging programs are not readily available (Bourgeault et al., 2010).

The literature cites several barriers to IEN participation in bridging programs. These include geographic mal-distribution, in that bridging programs are generally clustered in urban areas, the length of time required to complete a program and the associated loss of income, and tuition (Atack et al., 2012). IENs' participation in bridging programs is adversely affected by the isolation and provisional funding scheme associated with these programs (Duncan, Poisson, & Wong, 2008). While the literature describes the different types of bridging program, it does not identify which ones are the most effective.

Alternative employment as a path to professional recertification. Five papers discuss the influence of alternative employment on professional recertification. One of these focuses on IENs, particularly from the

Philippines, who enter the country under the Canadian Live-in Caregiver Program to care for children, the elderly, or the disabled (Bourgeault et al., 2010). Some IENs working as live-in caregivers intend to recertify after fulfilling their initial work contract (Blythe & Bauman, 2009). This type of employment affords IENs an opportunity to develop their social networks, improve their language and communication skills, and learn about the culture of health care in Canada. However, they also create obstacles to recertification. IENs working as caregivers often do not have the time to participate in bridging programs or to prepare for the licensing examination (Salami & Nelson, 2014). The inability to pursue recertification, in combination with their absence from nursing, puts IENs with this type of employment at risk for never resuming their profession in Canada (Baumann, Blythe, & Ross, 2010; Sochan & Singh, 2007). The literature does not address IENs working in other health-care jobs as paths to professional recertification.

Workforce Integration

The literature on workforce integration provides some insights into IENs' experiences when attempting to enter the nursing workforce in Canada ($n = 14$). This literature focuses on the facilitators and barriers that IENs encounter during their initial job search.

Barriers and facilitators. IENs are more likely to be hired if they have nursing experience in Canada or in a country with an equivalent health-care environment, have strong language skills, and are willing to work in hard-to-fill sectors of the health-care system (Baumann et al., 2010). IENs who prearranged their employment through recruitment agencies or migrated with employer-sponsored work contracts seem to enter the labour market more quickly than those who begin their job search after arriving in Canada (Bard, 2009).

IENs can have difficulty securing employment in their chosen setting or clinical area (Blythe et al., 2009). Many IENs feel unwelcome or discriminated against when looking for work (Turrittin, Hagey, Gurgue, Collin, & Mitchell, 2002). Some are forced to work for temporary placement agencies or as health-care aides (Salami & Nelson, 2014).

The literature cites two reasons for employers' failure to hire IENs. First, employers do not hire IENs if they believe that IENs lack the nursing knowledge, expertise, or language skills necessary to practise safely. Second, employers often lack the financial or human resources required to provide the education and mentoring IENs need to successfully integrate into the organization (ANIW, 2005; Baumann, Blythe, Idriss-Wheeler, Fung, & Grabham, 2013). There is little information available about the processes that IENs use to pursue employment. In-depth investigation into the hiring process from the employer's perspective is also lacking.

Workplace Integration

The literature on workplace integration shows that even after IENs secure employment they continue the integration process (Murphy, 2008). A total of 35 papers examine issues associated with IEN workplace integration.

Barriers and facilitators. Thirteen papers draw attention to the difficulties encountered by IENs while adjusting to nursing in Canada (Tregunno, Peters, Campbell, & Gordon, 2009). For example, some IENs find it a challenge to adapt to the assertiveness of Canadian nurses and the manner in which they communicate with doctors (SRNA, 2008). Some IENs also have difficulty acting as patient advocates or applying the concepts of legislation and jurisprudence to nursing practice (Baumann et al., 2006). Neiterman and Bourgeault (2013) describe this phenomenon as lack of cultural competence, explaining that cultural differences can adversely affect IENs' integration. Mentorship, managerial support, participation in employer-sponsored orientation programs, and development of nursing knowledge, language skills, and professional vocabulary can help IENs develop cultural competence and integrate into the workplace (Salma, Hegadoren, & Ogilvie, 2012).

Racism and Discrimination

Twenty-two papers describe the racism and discrimination that IENs experience in the workplace (Hagley et al., 2001). The literature includes examples of the behaviours and policies that IENs perceive as racist and discriminatory, such as denial of professional development and social exclusion (Turritin et al., 2002). The literature does not address employers' responses to racism and discriminatory practices directed at IENs. Baumann et al. (2013) report on a multimodal resource designed to assist employers with recruitment, hiring, orientation, and ongoing support to IENs. This informational and strategic resource was found to increase employers' awareness of the potential for racism and discrimination directed at IENs in the workplace.

Discussion and Recommendations for Research

This scoping review has revealed the small amount of research conducted on IENs in Canada. The lack of evidence has resulted in limited information being available about the IEN population, especially those IENs who are not registered with a regulatory college in Canada. More in-depth information about IENs — their immigration status, education, nursing expertise, and professional intentions — would be helpful in tailoring programs and policies to the needs of IENs who experience difficulty or who decide to withdraw from the professional recertification process. Such information could also help in determining whether the policies and programs designed to facilitate professional integration enable most IENs to recertify and practise nursing in Canada.

Many resources have been developed to support the professional recertification of IENs, such as assessment centres, language courses, and bridging programs. However, there is very little empirical evidence regarding their effectiveness. This lack of evidence affects our ability to modify or develop best practices as well as to substantiate their ongoing financial support. Also, since the resources available to help IENs recertify vary considerably across the country, comparative analyses of bridging program models and curricula are needed. We also need to increase our understanding of how alternative forms of employment, within and outside the health-care milieu, influence IENs' ability to recertify.

While we have an appreciation of the push and pull factors in IENs' migration to Canada, we have little understanding of how these factors influence professional recertification and employment. We also know very little about the long-term outcomes of direct recruitment initiatives. We need more research on how push and pull factors influence IENs, the organizations in which they work, and the Canadian labour market.

Lacking also is comprehensive information about the processes that IENs engage in when searching for work and the factors that influence their employment decisions. Exploring the hiring process from the perspective of employers would deepen our understanding of their decisions with regard to hiring IENs. Additional research is also needed to develop evidenced-based strategies to support and retain IENs once they have been hired. Further investigation into the discriminatory practices and racism encountered by IENs in the workplace and employers' role in addressing these behaviours is warranted.

The influence of language fluency on IENs' professional recertification and integration into the workforce and the workplace is an area that requires further study. There is limited discussion in the literature about the degree of fluency required to successfully practise nursing in Canada. How IENs' language proficiency affects career advancement opportunities, interprofessional teamwork, and patient safety is another important area for future research.

Conclusions

This scoping review has revealed that the literature on IENs in Canada is focused on the initial stages of IENs' integration, specifically the ethics of international recruitment and the methods of and strategies for expediting the credential verification and assessment process. The literature also indicates that professional organizations and governments have developed a variety of resources to help IENs navigate the integration process. However, more research is needed to evaluate their effectiveness and identify promising practices. Additional evidence will help governments, both domestically and internationally, modify, maintain, and develop programs to facilitate the integration of IENs into the workforce.

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Acknowledgements

Funding for this project was provided by the Canadian Institute of Health Research, Health Canada, and the Canadian Health Human Resources Network.

Conflict of interest: None

Scoping Review of the IEN Literature

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CJNR 2014, Vol. 46 Nº 3, 46–64

Fitting Square Pegs Into Round Holes: Doing Qualitative Nursing Research in a Quantitative World

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The authors, as doctoral candidates and registered nurses, took on a qualitative research project investigating nursing practice in a research-intensive organization. Their aims were to explore and describe how nurses in the ambulatory care setting assist patients and families, including how nursing practice was carried out, constraints to practice, and the influence of the interprofessional milieu. Their first finding, in part because of the qualitative research design used, concerned the potential impact of the organizational ethics review process on the project. The authors discuss how the language, definition of risk, and notion of informed consent articulated in the organizational review process influenced both the research timeline and (potentially) the study itself. While not dismissing the value of ethics review, they explore the tension of overlaying generic criteria for quantitative research, specifically randomized controlled trials, on nursing research from other traditions.

Keywords: nursing research, qualitative research approaches, human subjects, ethics review, informed consent

CJNR 2014, Vol. 46 Nº 3, 46–64

Résumé

Enfoncer des chevilles carrées dans des trous ronds : la recherche qualitative dans un monde axé sur le quantitatif

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À titre de doctorantes et d'infirmières, les auteures ont entrepris un projet de recherche qualitative visant à examiner les pratiques infirmières au sein d'une organisation axée sur la recherche. Cette étude a pour objectif d'explorer et de décrire la façon dont les infirmières en soins ambulatoires œuvrent auprès des patients et des familles, y compris la prestation des soins infirmiers, les contraintes de la pratique et l'influence du milieu interprofessionnel. En raison du choix de la méthode de recherche qualitative utilisée, les premiers résultats de l'étude portent sur l'impact potentiel du processus d'examen déontologique organisationnel sur le projet. Les auteures se penchent sur l'influence qu'exercent le langage, la définition du risque et la notion de consentement éclairé établie dans le processus d'examen organisationnel sur l'échéancier de recherche et (potentiellement) sur l'étude même. Bien qu'elles ne minimisent aucunement la valeur de l'examen déontologique, elles explorent la tension qu'entraîne la superposition de critères génériques en recherche quantitative, particulièrement les essais cliniques randomisés, sur la recherche infirmière issue d'autres traditions.

Mots clés : recherche infirmière, recherche qualitative, examen déontologique, risque, consentement éclairé

Many health-care organizations value and commit to research practices as part of their mission to improve the quality of life of those they serve. Our experience as doctoral candidates and registered nurses conducting qualitative research suggests that enacting those values and commitments is not always a straightforward matter. Our study was focused on nursing practice in an ambulatory care nurse-run patient support clinic (PSC) within a research-intensive cancer care organization. When we initiated the project, titled An Examination of Activities in the Patient Support Clinic: A Descriptive and Exploratory Study, we assumed that the research environment and attendant procedures would be supportive. However, it became challenging to conduct qualitative nursing research in an organization that explicitly and implicitly privileges quantitative medical research and the worldviews that support the dominance of this kind of research.

Perhaps most challenging was the ethics review and approval process, in particular having to fit elements of our qualitative research proposal into criteria and categories established for clinical trials and other traditional scientific research — primarily randomized controlled trials (RCTs) — conducted in this setting. Assumptions about what constitutes an ethical research endeavour, and changes required of qualitative researchers by human research ethics boards to reflect them, have a significant impact on nursing research and the knowledge it generates.

In this article we describe the language, definition of risk, and concept of informed consent embedded in the research ethics board (REB) application, which is designed mainly to protect participants in *quantitative* studies from harm. The REB in question is specific to this cancer care organization and does not review applications for research in acute care or community settings. We also comment on the ways in which these elements shaped the ethics approval process we undertook and the implementation of our study. Our aim is to explore tensions arising from applying generic criteria for quantitative research to nursing research in other traditions. We raise important questions about what it means to conduct qualitative nursing research ethically in traditional scientific research environments and suggest ways to ameliorate the ensuing difficulties.

Background, Setting, and Proposed Research Project

Our nursing research was conducted in a medically dominated cancer care organization in western Canada. Several years earlier, the organization had established RN-run PSCs in the ambulatory care setting in order to create time and space for nursing assessment and intervention, facilitate interprofessional communication, and help patients to navigate the complexities of the organization itself and related community-based services. Previously, RNs had worked directly with physicians and their practice had been largely directed by physicians in the ambulatory care setting. The nurse-run PSCs were designed to allow RNs to address patient needs regarding symptom management, education, and referral to community services outside of scheduled physician appointments.

Our project was intended to explore and describe RNs' practice in the PSCs to determine the nature of the assistance they were providing to patients and their families, how nursing practice was being conducted in this setting (including constraints to practice), and the influence of the interprofessional milieu, including referral practices of non-nursing professionals to nursing care.

Ours was a descriptive, exploratory qualitative research design consisting of (a) observations of nurses practising in the PSC; (b) in-depth interviews with these observed nurses and with other PSC nurses (not all wished to be observed); (c) post-observation interviews with patients about their experience with the nurse; and (d) in-depth interviews with various other organizational stakeholders whose professional practice intersected with that of PSC nurses: medical oncologists, care aides, counsellors, volunteers, and administrative personnel. All interviews were to be semi-structured and individual. All research activities were to take place within the organization; none were planned off-site or outside working hours (8:30 a.m.–4:30 p.m., Monday to Friday).

Registered Nurses and Research Ethics

Traditionally in this organization, RNs' involvement in research typically entailed collecting data as part of medical and/or pharmaceutical research protocols, in particular RCTs. Indeed, during one shift we observed RNs collecting data for up to 14 different RCTs. Although there are various quantitative approaches to inquiry, in this environment the RCT is considered the gold standard and dominates the research landscape.

The REB in this organization consisted primarily of physicians with extensive RCT training and experience. It also included a senior nurse administrator with a doctorate in nursing and considerable qualitative research experience. She was involved in our project and had to recuse herself from the review to allay concerns about conflict of interest. To our knowledge, no other professional in the organization had the experience or knowledge necessary to review applications for qualitative research. A substitute was not enlisted, as far as we can ascertain, nor were we invited to meet with any members of the REB. The organization appeared to have no mechanism in place for researchers to consult directly with the REB prior to submitting an application, nor did we consider this necessary based on our experience with submitting ethics applications elsewhere.

We are not implying that qualitative research is somehow superior to quantitative. We agree with Ercikan and Roth (2006) that to take quantitative and qualitative approaches dualistically is potentially polemic. As Blegen (2009) reminds us, debate about the relative merits of the two approaches is "beside the point" (p. 381); knowledge generated through research potentially informs practice decisions and must align with desired outcomes. This applies equally to quantitative and qualitative research. We do not wish to engage in a polarizing debate about research approaches. Rather, our aim is to highlight the effects on one nursing study conducted qualitatively of a review by one REB whose focus and knowledge base were primarily quantitative.

We respect the value of the ethics review process even while exploring the tensions arising when generic criteria for clinical trials are applied to research using other approaches. Points of tension were evident in three aspects of the ethics review process.

Firstly, the language used in and required for the human research ethics application process, such as establishing the "subjects" of the study, and the need for a particular kind of research protocol, revealed different (and sometimes conflicting) understandings of research design.

Secondly, the protocol governing informed consent for patient participants constrained our efforts to have informed consent procedures approved; obtaining informed consent differed significantly from our expectations (and those of the REB).

Lastly, the definition of "risk" drawn from its application to clinical trials was applied stringently (and, we believe, inappropriately) to our proposal, with the REB ignoring the stated objectives and method of our qualitative study. Although the focus of risk was patients as research participants, this emphasis inadvertently challenged aspects of our approach as problematic; paradoxically, it also minimized the risk of exposure of employee participants working in a relatively small organization, something we as researchers constantly grappled with, apart from the formal ethics review.

Ethics Review Process: Square Pegs in Round Holes

The application forms we were required to complete for the ethics review had been drawn up within a worldview in which the research being conducted is assumed to be quantitative. As qualitative researchers, we felt we were reading an application form meant for another group of researchers, questioning the pertinence of various categories to our research (and to a qualitative approach). We were like square pegs trying to fit into round holes.

Although not intentionally, the application forms constructed a binary between objective (*value-free*) and subjective (*value-laden*) research approaches, with objectivity being highly valued. Simply put, not only did we have to tailor our application to its requirements (and language), the REB missed, or misread, or failed to recognize our intention to conduct research with a variety of participants using a qualitative interview-based approach. We had to rewrite several parts of the application to meet requirements that could pertain only to quantitative studies (e.g., develop a detailed prescriptive research protocol). Such constraints are not without effects. Unlike the university ethics approval process familiar to those doing qualitative nursing research, which, for us, took 2 months, this review process extended over several months, greatly impacting our research timelines and funding deadlines. Such implications are explored in the literature on education research (Lincoln & Tierney, 2004) and sociology research (Tolich & Fitzgerald, 2006).

The "Subject" of Language Games

With respect to language, tension mounted because of the REB's difficulty recognizing the "subject" of our research. We were proposing to conduct short, semi-structured qualitative interviews with patients *after* they had been seen by RNs in the PSC, but also to interview RNs after observing their practice in the PSC as well as nurse participants whose practice we had not observed. We also proposed to interview other stakeholders in the organization, such as care aides, managers, counsellors, clerks, and physicians.

The REB's difficulty recognizing the subject of the research was compounded by our own challenges in identifying the subject, given the positivistic definition of "subject" implicit in the pro forma application: "an organism (human or otherwise) that is observed for purposes of research" or "person upon whom an experiment is made" (*Oxford English Dictionary [OED],* 2014). For example, the section of the application form on inclusion criteria stated: "Describe the subjects being selected for this study, and list the criteria for their inclusion. For research involving human pluripotent stem cells, provide a detailed description of the stem cells being used in the research." Other examples: "A. How many subjects (including controls) will be enrolled in the entire study? (i.e., the entire study, world-wide) . . . B. How many subjects (including controls) will be enrolled at institutions covered by this Research Ethics Approval? (i.e., only at the institutions covered by this approval)? Of these, how many are controls?" We were stymied by this requirement, particularly as there was no "not applicable" option on the form.

Given our qualitative methodological orientation, we understood that there were no "subjects" in our study. We indicated this to the REB in plain language and completed the form, stating that there were many potential *participants* in the research, such as RNs, patients, physicians, care aides, counsellors, and administrative staff. After the first revision in which we explicated our conceptualization of participants, our proposal was returned to us for revisions, with the following question: "If the patient is not the subject, and the RN is not the subject, then what is the subject?"

At this point we realized that we would have to use the quantitative language of RCTs — to identify a subject fitting this REB's criteria for research subjects. We informed the REB that the "subject" (in our language, the "phenomenon of interest") was the practice of RNs in the nurse-run PSC, that we had planned a study with a variety of participants who would speak about their understanding of nursing practice (the subject) in this setting, and, for those not working in this setting, how their work intersected with nursing practice (the subject).

As well as making these revisions acceptable (and understandable) to the REB, we were required to construct a "protocol" for the study — another source of tension for us. By definition, a protocol is an essential component of an RCT. It constitutes detailed instructions for the "method or procedure for carrying out an experiment, investigation, or course of medical treatment" (*OED,* 2014). Underlying the demand that we construct a protocol, as for an RCT, was the "assumption that the world is knowable in advance and the research and its outcomes are predictable" (Tolich & Fitzgerald, 2006, p. 72). The foundation of our understanding of research, conversely, is that the design is emergent and the world is contextual, socially constructed, and ultimately unknowable in advance. This tension contributed to our sense that the application process was something of "a charade," in the words of Tolich and Fitzgerald (p. 72).

As qualitative researchers, we were stymied by the demand for a protocol. In the qualitative tradition in which we were educated as nursing doctoral students, the word "protocol" is not in common usage. We realized that, for this organization, it had a specific non-qualitative research meaning. We were also accustomed to relying on emergent design, appropriate to our research activities, which would not require step-by-step instructions. In addition, we believed that it would be misleading to prescribe a protocol for an anticipated emergent design, given the flexibility we relied upon as the research unfolded.

We decided to develop a shortened version of our research proposal, outlining our method and including as much detail as possible. Our concern was that a specific protocol might constrain our flexibility in responding to local conditions as they emerged in what was an exploratory descriptive study. As qualitative researchers, we were oriented to being open, responsive, and reflexive with respect to the phenomenon of interest, adjusting the research process as needed during the investigation while carefully attending to ethics considerations and requirements.

Our approach and our dilemma are reflected in Tolich and Fitzgerald's (2006) description of navigating ethics approval for their ethnographic studies. If we had been cognizant of ethics review challenges prior to submitting the application, we could have followed the recommendations of Ells (2011) and van den Hoonaard (2002b) and perhaps experienced less difficulty. However, we found few such discussions in the nursing literature (e.g., Munhall, 2007), particularly in a Canadian context, and had not had explicit conversations about this issue over the course of our graduate studies.

In the end, our creative response to the REB proved satisfactory, given the stated requirements, yet we were not informed of the rationale for the REB's approval of our approach to protocol. REB members may have felt uncomfortable with how our research was described — we initially submitted an account of how it *might* progress. Protocol can also mean "the accepted or established code of behaviour in any group, organization, or situation" (*OED,* 2014). We believe that tension between worldviews can expand the code of behaviour embedded in organizational research practices, resulting in a more robust examination of a variety of relevant phenomena.

Still, as we had no experience with REBs unacquainted with qualitative research methods, this was not our only hurdle. As we completed this part of the REB application, we faced another challenge.

Informed Consent

Historically, informed consent evolved as a response to unethical research practices that resulted in harm to human beings. The Nuremberg Code (National Institutes of Health, 1949) (which begins with the statement "The voluntary consent of the human subject is absolutely essential"), the WMA Declaration of Helsinki (World Medical Association, 1964/2008), and the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979) are documents that inform international ethics guidelines, including the guiding document for Canadian university and health-care research ethics boards, the Tri-Council Policy Statement (TCPS) (Canadian Institutes of Health Research [CIHR], 2010).

The right to free and informed consent when participating in research is unequivocal. Over the past two decades, largely in response to legal action in the United States, informed consent has become a focus of research ethics conversations to the extent that "one might be led to think erroneously that other ethical issues (e.g. research design, selection of participants) are either less important or more satisfactorily resolved" (Levine, 2003, p. 197). Failure to obtain informed consent is considered a form of negligence in both the United States and Canada, with possible legal consequences (Levine, 2003). An organization's ethics board could be held accountable if informed consent procedures are not specified in ethics review applications.

RCTs customarily allow prospective subjects at least 24 hours to decide whether to participate so that they do not feel coerced. However, our research design did not require participants to submit to a medical procedure or to ingest a medication. Our intention was to observe patients and RNs together and to conduct interviews. RNs working in the PSC do not know 24 hours in advance who they will be seeing in the clinic on any given day (including on our scheduled observation days). Also, it was impossible for us to identify patient participants in advance of their referral (usually on the same day) to the clinic; informed consent could be obtained only in the clinic when we met the patients for the first time. Because of this, and because of the unpredictable nature of RNs' practice in the clinic, our proposed informed consent process did not (and could not) allow patients 24 hours to make their decision.

The REB required us to justify this digression from informed consent guidelines and indicated concern that our patient participants would be vulnerable to coercion. We also had concerns about coercion, in particular about approaching patients immediately prior to their seeing an RN, disrupting the flow of RNs' work, and troubling patients who might already be emotionally and physically compromised, distressed, or vulnerable. Qualitative researchers often do have difficulty ensuring confidentiality (Snyder, 2002); however, in-the-moment consenting processes are common in qualitative nursing research and are within the ethical boundaries outlined by the TCPS (CIHR, 2010).

We knew the importance of informing patients that they had the option of not participating and of quitting the research if it became uncomfortable, exhausting, or onerous at any time during the observations or interviews. Wording the informed consent section of the application in ways that would satisfy the REB included this option for patient participants, along with several scenarios based on our understanding of the referral processes to the clinic. Our concern was to explain to the REB that referral processes could influence the amount of time available to patients to consider whether to participate, and these differed from patient to patient.

Our revision asserted that our study was designed to consider current referral practices (and their influence on RN practice in the PSC) and that we had incorporated these into the informed consent process in part to minimize any added burden and anxiety for patients. We reiterated that our study was designed to capture patient–nurse interactions verbatim as they occur in everyday practice rather than recollections, which can be inaccurate.

Ironically, later, as we entered the field and began our observations of RN–patient interactions, the REB's heightened concern over patient informed consent proved to be moot. Every patient of this cancer care organization receives a detailed orientation to its practices, procedures, and personnel, delivered electronically and most often accessed at home. The orientation stresses the values of the organization, explaining repeatedly that it actively engages in research and that patients and their caregivers may be asked by staff to participate in various research projects. When seeking informed consent in the field, we directly benefited from this socialization/education of patients in the research culture of the organization, something the REB did not take into account when considering our qualitative design. While we had been concerned that it might be a clumsy, disruptive process, patients readily consented, most citing a desire to contribute or to make a difference for others. Such a response justifies the call for a re-evaluation of the notion of informed consent, particularly in terms of risk, and for the incorporation of greater flexibility (van den Hoonaard, 2002a).

Risk

The notion of risk is important in health-care research because of the Western bioethics principle of non-malfeasance, a principle that encompasses many explicit ethical imperatives such as "do not kill," "do not cause harm," and "do not incapacitate" (Beauchamp & Childress, 2013, p. 154). Risk, in this sense, is the potential for harm to the participant. Taking potential benefits into account, "the level of foreseeable risk posed to participants by their involvement in research is assessed by considering the magnitude or seriousness of the harm and the probability that it will occur" (CIHR, 2010, p. 196). Research projects deemed to be of minimal risk usually receive an expedited review, while those assessed as higher than minimal risk require an intensive, extensive full board review and progress reports at regular intervals. We agree that scrutiny of risk is an important consideration for every research project, and we are curious about how concepts like risk are interpreted by members of ethics review boards, including how such concepts might disadvantage those doing qualitative research.

Before we were asked to undertake this project, the researchers previously responsible for it submitted an application for ethics review proposing a participatory action research (PAR) design. In this organization, we were surprised to discover, action research is automatically categorized as above minimal risk and requires a full REB review. The project had been considered above minimal risk because it would involve RN participants in the (action research) design and implementation. The risk category at which that project was assessed was also applied to our project, and the REB met only once a month, which meant that any revisions we were required to make because of the initial designation as above minimal risk would significantly delay our project.

When we assumed responsibility for the project we changed the research approach and expected that the former design would have no relevance for the ethics review. But from the perspective of the quantitatively oriented REB our proposal did not differ substantially (along the parameters with which they were familiar) from the initial one; thus it treated our project as a PAR study, in terms of risk, despite the changed approach (and, we believed, lower risk category). The PAR designation could not be removed from the application: we would have to submit a new application, which our funding timelines did not permit.

It appears that the majority of REB reviewers were not sufficiently familiar with PAR, nor, for that matter, with qualitative interview design, to see that our design was not PAR — although we acknowledge that we should have been more explicit, in our application, about the difference. Our project would have looked very different had we used a PAR method. Perhaps the REB's focus was the above minimal risk element, not the more-or-less generic qualitative interview design described in our application, which we understood to be of minimal risk. We have since discovered that qualitative nursing studies are often assessed by health-care REBs as entailing substantial risk and are classified as "behavioural studies" requiring full board review. This classification baffles us given that some RCTs involving experimental medications could be designated as minimal risk, depending on the protocol. It transpires that an emphasis by REBs on risk in qualitative research designs is not unusual (van den Hoonaard, 2002a). The main purpose of such organizational practices could be to protect the legal interests of the organization (Lincoln & Tierney, 2004).

The REB expressed no specific concerns about the risk to other participants, including RNs, despite the small size of the organization and the challenges to confidentiality that we imagined. We struggled constantly with this aspect of risk, and we modified our research design to ensure the confidentiality of RNs and other stakeholders, a challenge inherent in qualitative interview research in smaller health-care organizations. For example, a portion of the research budget was dedicated to backfill or release time so that RNs could be interviewed during their shifts in meeting rooms away from the PSC, thus both ensuring that staff would be available to meet patient needs and minimizing the amount of time an RN would be seen with us in the PSC.

We discovered, however, that the organization had very particular and stringent requirements for obtaining approval for release time. Making a request on behalf of RNs for paid release time for the purpose of an in-depth interview would immediately identify the participant to the manager (and others). To substitute for this process, with its risk to confidentiality, we were required to spend much more time within the organization waiting for nurses' downtime in the ebb and flow of clinical practice in order to interview them during regular working hours. We did ask nurses if they preferred to be interviewed outside the workplace but all declined. We also arranged with managers to have them not enter the PSC during specified, agreed-upon periods when we would be observing practice. While we never disclosed the name of an RN we were observing, we did inform the manager of exactly when we would be observing in the PSC.

The RNs working in the PSC were aware of the risk. We had difficulty with recruitment because they believed it would be difficult for us to protect their confidentiality. Such organizational difficulties are not uncommon; we encourage nurse leaders and nurse researchers to carefully consider how organizational structures affect nurses' participation in research. If we are to build on current nursing knowledge and support the implementation of nursing research, while drawing on the expertise of nurses in practice (beyond their traditional role as RCT data collectors), it is crucial that we recognize the kinds of barriers described here and institute formal structural processes to facilitate nursing research (Weierbach, Glick, Fletcher, Rowlands, & Lyder, 2010).

Discussion: Imagining Our Fathers' Ethics Board

Initially we believed our experience to be unique; there is a dearth of discussion in the nursing literature regarding the politics of submitting an ethics application. While there is much discussion regarding the tensions between qualitative and quantitative research perspectives, and extensive debate about what constitutes the gold standard of health-care research (e.g., Blegen, 2009), there is little on the translation of such tensions into the practice of research and the issues that emerge from that translation. Thus, the extent of the problem for Canadian nurse researchers is not clear. Informal polling of our research and doctoral colleagues in nursing revealed that the kind of tension we describe is common, a finding that is congruent with descriptions and analyses of the issue amongst qualitative education researchers a decade ago (Lincoln & Tierney, 2004).

Anecdotal evidence points to the need for close attention to this issue. Some of the nurse researchers with whom we discussed our experience remarked that they have been told by members of REBs that their proposed qualitative research (such as action research) was "not even research" or have been required to construct detailed protocols to address exaggerated risks to participants, such as death during qualitative interviews. In light of the competition for research funding, it is vital that REB knowledge gaps regarding qualitative design be addressed. Nurse researchers risk having their studies discounted or substantially altered during ethics approval, as they shape their research projects to the quantitative orientation of traditional REBs.

The privileging of quantitative methods and philosophical perspectives by REBs can be seen not as a research practice but as an organizational practice that serves "methodological conservatism" (Lincoln & Canella, 2004, p. 7), reminding nurse researchers and other nurses that the RCT is the gold standard of knowledge production. Like other organizational aspects of health care and research, REBs need to be evolving constantly, to account for innovative research methods that address contemporary health care and ethical issues unimagined by the ethics boards of our fathers.

Further reflection on our experience prompted us to consider how nursing knowledge is shaped during the ethics approval process. We therefore offer some suggestions to supervisors and mentors of doctoral students, REB members, and qualitative nurse researchers. Our purpose is to engage nurse researchers in exploring this topic and shaping the context of nursing research.

Supervisors/Mentors

Within the supervisor–doctoral student relationship, the ethics application can be seen as a vehicle for discussing the politics of nursing research. This goes beyond what Hemmings (2006) describes as strategies for enabling doctoral students to complete their degrees and resist the undermining effects of rejection by REBs. As Hemmings points out, doctoral students with difficult research questions may abandon their original interests and pursue topics that have already been investigated or that are without controversy, in response to difficulties encountered during ethics review. Organizational research practices that reject innovative or boundary-pushing inquiries can also have the effect of further depleting the number of qualitative researchers in the field (Hemmings, 2006). Such redirection of nursing research is unfortunate for the profession and discipline of nursing.

We suggest that doctoral students meet ahead of time, if possible, with the REB coordinator. The purpose of the ethics application process is to ensure the safety and consent of participants, not to inflict hardship or to discredit any research tradition or methodology. Supervisors should, if necessary, "speak with [REB] members, defend the research that they or their students are undertaking, and seek to educate [REBs] more broadly concerning issues of level of risk and potential direct benefits" (Lincoln & Tierney, 2004, p. 233). Such actions go hand in hand with the supervisor's guidance in helping students see the difference between filling out application forms incorrectly and recognizing the inherent privileging of certain research traditions. Inexperience and incomplete or carelessly completed applications are salient factors in prolonged and inadequate approval processes (Burke, 2005; Hemmings, 2006) and can be viewed as disrespectful of REB members' time and efforts.

We believe it is vital that doctoral supervisors discuss ethics applications and the ethics review process with their students in a fair manner, rejecting the idea that the process is a barrier to research or that the application form is a stagnant document. The ethics review process could be discussed as a potential issue for qualitative nursing researchers in the field. Ethics review can be a deep-rooted research issue requiring skilful management and re-imagination by qualitative researchers present and future. The ethics application can also be, as it was for us, the beginning of a process of informing nurse researchers about the power dynamics and values of the organizations in which nurses work and where nurse researchers conduct research.

Research Ethics Boards

Based on our experience and our review of the literature, we concur with van den Hoonaard (2002a) that the detrimental effects of privileging certain research traditions are most keenly felt by doctoral students. Doctoral students are particularly vulnerable and have not yet had an opportunity to build a strategic research network. We wish to contribute to the strengthening of REB–doctoral student relationships in order to support the development and sustainment of researchers from a variety of traditions. We echo van den Hoonaard's (2002b) call for REBs to "look at education, not policing": "REBs should concentrate on ethical issues, not scientific, legal" or on risk management considerations (p. 183). Education and translation of ideas are not unidirectional, and they involve critical consideration of language as well as the need for collaboration and communication.

It is of the utmost importance that more inclusive language be incorporated into the ethics application process (van den Hoonaard, 2002a). This includes language around notions of risk and protocol. If risks to a participant are known, as they purportedly are in RCTs, then "ethics review can be more structured and less ambiguous" and thus more accessible to applicants (Tolich & Fitzgerald, 2006, p. 76). While, on the surface, the requirement of a traditional protocol seems a tidy solution, ambiguity is, in the 21st century, inherent to all research. According to Ells and Gutfreund (2006), it is a myth that all "risks and benefits must be known in advance" (p. 368). The TCPS concurs: "[C]ertain accepted research paradigms bring inherent limitations to the prior identification of risk. For example, when research in the social sciences employs emergent design, the manner in which the research project will proceed and any associated risks may be known only as it unfolds" (CIHR, 2010, p. 23).

It is illusory to believe that any protocol will remain unchanged after it is presented to and approved by an REB. Researchers need to acknowledge and account for both ambiguity and flexibility during the ethics review process, without overstating (or understating) the risks entailed in qualitative methodologies. Acknowledging this reality can encourage REBs to focus on ethical principles rather than on the mechanics of "proper" application, such as "Is there a hypothesis?" or "Is anonymity of the participants protected?" (Ells & Gutfreund, 2006, p. 372).

While we recommend the use of inclusive language in REB applications, REBs could adopt collaborative organizational practices that promote mutual trust and instil confidence in the assertion "that investigators will follow the human subjects [participants] aspects of their protocols" and that REBs "are interested in advancing research" (Burke, 2005, p. 924). A good example of organizational collaboration would be an REB comprising representatives from multiple disciplines with different perspectives and research interests, extending beyond one token nurse or even one qualitative researcher. If interested parties are not available within the organization, cross-appointments with affiliated academic units might be considered (Lincoln & Tierney, 2004). This could serve not only to facilitate the ethics review of qualitative research applications but also to educate other board members in qualitative methods (Lincoln & Tierney, 2004). Interdisciplinary collaboration supports communication between boards and researchers, resulting in learning opportunities and minimizing organizational practices that tend to "normalize" one particular research tradition (Burke, 2005; van den Hoonaard, 2002a).

Qualitative Nurse Researchers

While supporting Blegen's (2009) call for a reframing of the tired qualitative-quantitative debate, we also offer several suggestions to qualitative nurse researchers. First and foremost, they might consider joining an REB as a vital aspect of knowledge translation. Our experience illustrates how REBs inherently influence research practices embedded in organizational power arrangements and play a key role in the generation of new nursing knowledge. Knowledge translation is as much about power relations as it is about evidence (Newton, 2012). The translation of innovative research designs and of REB processes and politics in ways that are meaningful for doctoral students is vital to the future of qualitative nursing research.

We have also come to see the value of approaching an REB with the expectation that a collaborative process will enhance mutual understanding and strengthen the proposed research (Burke, 2005). We encourage researchers to include an explicit ethics discussion in their research proposal as part of the methods section (not as an appendix), as such discussion "permeates method and theory" (van den Hoonaard, 2002b, p. 181). As Lincoln and Canella (2004) state, "multiple kinds of knowledge, produced by multiple epistemologies and methodologies, are not only worth having but also demanded in policy, legislation and practice" (p. 7). In our own work, we consider comments from different perspectives.

The researcher has a responsibility to submit a clear and polished application (Ells, 2011; Hemmings, 2006). As our experience shows, good communication (Ells, 2011) and an accurate, clear application can ease many of the difficulties encountered during the review process. In the words of Morse (2003), it is the "responsibility of the applicant to prepare a persuasive yet balanced, comprehensive application . . . [and] the responsibility of the agency to provide a competent, valid and fair review" (p. 850).

Finally, we recommend that qualitative nurse researchers share their stories with neophytes. There is no doubt that many nurse researchers have creatively and innovatively met the challenges that we have outlined and have been steadfastly submitting high-quality work to REBs, perhaps having to defend their work to misinformed or biased REBs in order to continue the research necessary to advance nursing as a profession and discipline. We did not realize until we spoke about our experience that prominent Canadian nurse researchers have been practising at the margins of tolerability in the current Canadian research ethics landscape, where the difficulties we describe have affected funding opportunities as well as the generation of new nursing knowledge.

Conclusion

We acknowledge that the ethics review process is a crucial mechanism for protecting the safety and rights of all participants; without it the potential for harm would be significant. Our experience demonstrates that the taken-for-granted criteria used to ethically review and assess RCTs cannot be universally applied to qualitative research (nor, for that matter, to other forms of quantitative research). Different interpretations of language, informed consent, and risk embedded in the review process reveal tensions among various research approaches, and consequences for nursing research practice. In our case, the consequences included unnecessary delays and other problems, requiring us repeatedly (and creatively) to fit a square peg into a round hole.

Beyond our own research challenges in this reality, we are concerned about the trend towards what Lincoln (2004) refers to as "methodological conservatism" (p. 165) with its power to shape the design and implementation of any qualitative study. While it has long been acknowledged that qualitative traditions are necessary to examine many phenomena of concern to nursing, traditional institutional research supports in health care are organized around the implicit privileging of quantitative methods. Such organizational arrangements have the power not only to influence how nursing research is implemented, but also to shape new nursing knowledge before it is even generated.

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Acknowledgements

The authors acknowledge funding from the Canadian Nurses Foundation and the Stephen Berg Fund. Lorelei Newton acknowledges funding from the Social Science and Humanities Research Council of Canada in the form of a doctoral fellowship and from the MITACS Accelerate Internship Program.

The authors would like to thank Drs. Mary Ellen Purkis and Maxine Alford for their generous support and feedback. The authors are also grateful for the helpful comments of the anonymous reviewers.

Conflict of interest statement: The authors declare that there is no conflict of interest.

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CJNR 2014, Vol. 46 Nº 3, 65–93

An Integrative Review of the Literature on Pain Management Barriers: Implications for the Canadian Clinical Context

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Despite decades of pain research, substandard pain management continues to be distressingly prevalent across health-care settings. This integrative literature review analyzes and synthesizes barriers to effective pain management and identifies areas for future investigation in a Canadian context. Three sets of key barriers were identified through thematic analysis of 24 original research studies published in the period 2003–13: patient, professional, and organizational. These barriers rarely occurred in isolation, with many studies reporting examples in all three categories. This suggests that interventions need to reflect the multifactorial nature of pain management. Reframing pain education as a public health initiative could lead to sustainable improvement, as could the strengthening of partnerships between patients and health-care providers. There are tremendous opportunities for the advanced practice nurse to take a lead in pain management. The delivery of high-quality care that encompasses effective pain management strategies must be a priority for nursing. Research approaches, such as pragmatic mixed methods, that offer contextual understanding of how pain is managed are suggested.

Keywords: pain management, nursing, healthcare professionals, barriers

Résumé

Un examen par intégration de la littérature traitant des obstacles à la gestion de la douleur : conséquences en contexte clinique canadien

Mia Maris Ortiz, Eloise Carr, Anastasia Dikareva

Bien que la question de la douleur ait fait l'objet de recherches depuis plusieurs décennies, la douleur est encore très mal gérée dans la plupart des milieux de la santé. Le présent examen par intégration de la littérature analyse et fait la synthèse des obstacles qui empêchent une gestion efficace de la douleur et identifie des domaines qui devront faire l'objet d'études en contexte canadien. Trois types d'obstacles ont été identifiés à l'aide d'une analyse thématique de 24 études originales publiées entre 2003 et 2013 : ceux qui relèvent du patient, ceux d'ordre professionnel et ceux de nature organisationnelle. Ces obstacles se manifestent rarement de façon isolée et nombre d'études offrent des exemples des trois types, ce qui suggère que les interventions doivent refléter la nature multifactorielle de la gestion de la douleur. Le recadrage de l'éducation en matière de douleur dans le cadre d'une initiative de santé publique pourrait mener à des améliorations durables, tout comme le renforcement des partenariats entre les patients et les professionnels de la santé. Les occasions qui s'offrent aux infirmières en pratique avancée de jouer un rôle de premier plan en matière de gestion de la douleur sont immenses. La prestation de soins de grande qualité qui s'appuient sur des stratégies de gestion de la douleur efficaces doit être une priorité en soins infirmiers. Les auteures suggèrent l'adoption d'approches de recherche offrant une compréhension contextuelle de la gestion de la douleur, telles les méthodes mixtes pragmatiques.

Mots clés : gestion de la douleur, soins infirmiers, professionnels de la santé, obstacles

The management of acute and chronic pain continues to be problematic in Canada (Lynch, 2011). A survey in a large Canadian hospital found 71% of patients reporting some pain experience, with 32% having moderate to severe pain and 11% severe pain (Sawyer, Haslam, Robinson, Daines, & Stilos, 2008). Approximately 15% to 19% of Canadians experience chronic pain, with the highest rates reported by women and those over the age of 65 (Reltsma, Tranmer, Buchanan, & Vandenkerkhof, 2011). Some believe that effective pain management across all health-care settings is an ethical right (Cousins, Brennan, & Carr, 2004; Olmstead, Scott, & Austin, 2010).

Background and Significance: Pain Management and the Experience of Pain

Nearly half of all patients living with poorly managed pain experience substantial costs to their daily lives (Cousins et al., 2004). Unmanaged pain can have long-term physiological and psychological consequences, such as increased susceptibility to depression, lower quality of life, reduced independence, and decreased functioning in activities of daily living (ADLs) (Coker et al., 2010; Lapane, Quilliam, Chow, & Kim, 2012). Chronic pain is also associated with immense economic, physical, and psychological costs (Kohr & Sawhney, 2005). It is estimated that the annual cost of pain management in Canada surpasses $10 billion (Reltsma et al., 2011). Persistent pain can lead to reduced productivity at work, resulting in financial costs to the economy and the individual (Lynch, 2011). Pain can limit activities and negatively impact mental health and interpersonal relationships, thereby reducing quality of life (McCarberg, Nicholson, Todd, Palmer, & Penles, 2008).

Effective pain management includes pain screening, assessment (ongoing assessment and reassessment), diagnosis, documentation (timely and appropriate), treatment (pharmacological and non-pharmacological interventions), and continuous evaluation of care (Registered Nurses' Association of Ontario [RNAO], 2007). Pain management should also include ongoing education and training of staff, clients, and clients' families regarding pain experiences and associated primary and secondary interventions (Health Care Association of New Jersey, 2006; RNAO, 2007). Primary interventions would be preventive — for example, education for patients with chronic pain surrounding pain management techniques. Secondary interventions refer to the direct treatment of pain at its onset, such as medication for patients complaining of pain from a bone fracture. Nurses play a key role in effective pain management (Ferrell, 2005; RNAO, 2007) and factors influencing effective pain management among health professionals are well documented (Brown, 2004; Prkachin, Solomon, & Ross, 2007; Sun et al., 2007). However, despite decades of extensive research, ineffective pain management continues to be ubiquitous in health care in Canada and in a number of other countries, such as the United Kingdom (Maier et al., 2010; Wadensten, Fröjd, Swenne, Gordh, & Gunningberg, 2011) and the United States (Carr, Reines, Schaffer, Polomano, & Lande, 2005).

Purpose of the Literature Review

This article explores and develops an analysis of the current literature on the barriers to adequate pain management. According to Torraco (2005), "an integrative literature review of a mature topic addresses the need for a review, critique, and the potential reconceptualization of the expanding and more diversified knowledge base of the topic as it continues to develop" (p. 357). An integrative review, also known as a scoping review, is aimed at elucidating gaps in the literature rather than answering specific research questions. Therefore, integrative review methodology is the broadest literature review approach (Whittemore & Knafl, 2005). However, the structure and format of an integrative review follow those of other literature reviews: background, methods, data analysis and results, discussion. Our specific focus stems from a desire to improve pain management in the clinical setting by identifying contemporary barriers. Though this review focuses on the context of nursing, literature concerning other health professionals is included, as this approach addresses the interprofessional collaboration that underlies clinical pain management initiatives (Carr & Watt-Watson, 2012).

Literature Search: Design and Data Analysis

The literature search and analysis were conducted according to methods described by Torraco (2005) and Whittemore and Knafl (2005). Three electronic journal databases on nursing research and clinical practice were used: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, and Health Source: Nursing Academic Edition. Additional articles were retrieved through back-chaining, which involves exploring the references listed in relevant articles for further literature. The search terms were "nursing," "pain management," "pain education," and "barrier." The term "barrier" refers to factors that impede effective pain management.

The primary inclusion criteria were as follows: (1) original research article, (2) primary or secondary research outcomes with a focus on barriers to effective pain management, (3) published in the English language (4) during the period January 2003 to October 2013 inclusive. The search timeline for integrative reviews varies, with some reviews requiring a snapshot of science over just a few months (Falk, Ekman, Anderson, Fu, & Granger, 2013) and others seeking to capture the impact of changes in mental health policy two decades earlier (Nurjannah, Mills, Usher, & Park, 2014). We chose 10 years, to reflect our aim of capturing a contemporary overview. We did not limit the search to Canadian studies, as we wished to gain an understanding of the international literature interpreted in a Canadian context. These parameters were meant to capture contemporary research in pain management (Whittemore & Knafl, 2005).

Two members of our team screened abstracts for eligibility criteria, independently labelling articles "inclusion," "possible inclusion," and "exclusion." If the abstract did not provide information sufficient to assess for inclusion/exclusion, the article was read in full. Differences of opinion regarding inclusion/exclusion stemmed predominantly from whether an article met the criterion of yielding primary or secondary research outcomes surrounding barriers to effective pain management. These differences were addressed through in-depth discussion and a full review of the article, arriving at consensus. All three team members participated in the final selection of articles.

The findings from each study were reviewed in detail by two members of the team to identify barriers to pain management. A list of barriers was compiled (as codes) and then subjected to thematic analysis using a matrix analysis (Miles & Huberman, 1994). This framework entails identifying themes from patterns and sequences of data that describe a phenomenon — in this case, "barriers" — which are then grouped together to form themes. The themes were arranged in a table to view patterns across the codes. For example, the study by He et al. (2010) identifies three barriers: patient noncompliance, heavy workloads of health-care providers, and insufficient time for health-care providers to perform in-depth pain assessments. Looking at these across the themes of patient, professional, and organizational barriers, it was possible to observe that the three are interrelated. Patient noncompliance can increase the workloads of health-care providers, as it can increase the time required for task completion. Heavy clinical workloads can decrease the time spent with patients, leading to ineffective interventions and in turn patient noncompliance, and so forth. Thematic analysis was performed by the first author and peer-reviewed at each stage by the other two authors.

Results

A total of 24 articles were included in the review. Of the studies, 14 were qualitative, seven quantitative, and three mixed-method. The search strategy and results are depicted in the PRISMA flowchart (Figure 1) (Moher, Liberati, Tetzlaff, Altman, & PRISMA Group, 2009). Thematic analysis revealed three interrelated barriers to optimal pain management: patient, professional, and organizational. The 24 studies are summarized in Table 1.

Figure 1 ***PRISMA Flowchart***

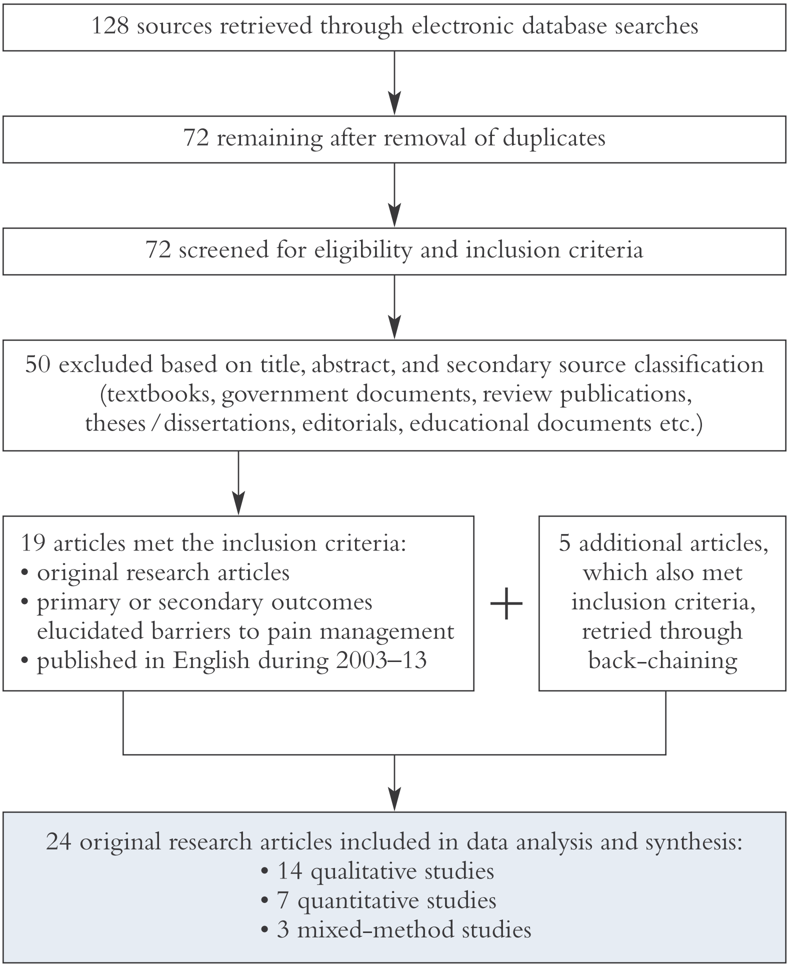

Table 1 ***Summary of Literature Identifying Barriers to Adequate Pain Management***

Publication (Country)	**Study Method**	**Sample Size and Context**	**Relevant Findings**	**Limitations**
Qualitative Studies				
Bergman (2012) (United States)	Individual interviews	Emergency nurses ($N = 15$) in 6 hospitals	Lack of cohesion within health-care team; inadequate staffing; unrealistic expectations of health professionals	Subjects had wide-ranging tenure (1–15 years), impacting practice experience; despite multi-centre recruitment, limited to geographical area
Breen et al. (2007) (United Kingdom)	Telephone interviews; focus groups	GPs ($N = 21$) with > 2 years' experience	Mismatched perceptions in the physician–patient relationship; lack of education, awareness, and local services for patients	No GPs practised in strictly rural settings; despite multi-centre and practice recruitment, limited to geographical area
Corazzini et al. (2013) (United States)	Telephone interviews	Nursing directors, RNs, LPNs working in 10 nursing homes	Inadequate staffing; reliance on LPNs to initiate majority of pain control initiatives	Data collection and analysis focused on comparative case studies; limited to 1 geographical area
Dysvik & Furnes (2012) (Norway)	Individual interviews; group-level reports	Nurse leader ($n = 1$), nurse group leaders ($n = 9$), 13 chronic pain groups (9–13 participants each)	Challenges in leadership on organizational, teamwork, and group levels	Purposive sampling used; recruitment methods/participant sources not stated; group discussions based on contributions vs. turn-taking
Fox et al. (2004) (Canada)	Focus groups	Physicians ($n = 6$), nurses ($n = 27$), health-care aides ($n = 13$), physiotherapists ($n = 8$) working in long-term-care institutions	Lack of caregiver pain knowledge and sensitivity; patient cognitive impairment; underreporting of pain; lack of documentation and time	Purposive sampling used; results of qualitative analysis not presented to study participants for final validation

Gregory & Waterman (2012) (United Kingdom)	Naturalistic unstructured observation; structured patient interviews	RNs (n = 18) on 7 wards; total of 38.5 hours of observation; patients (n = 19) on 5 medical wards	Nurses' multitasking prevented patients from discussing pain; minimal patient involvement — spoke about pain only when asked	Limited time spent performing naturalistic observation, and solely on day shifts; observer was also a participant as an RN on ward under observation; limited to geographical area
Jablonski & Duke (2012) (United States)	Written narratives; individual interviews	RNs (N = 10) caring for terminally ill patients in 100-bed rural hospital	Lack of pain knowledge; disagreement about patients' level of pain; lack of time	Small sample size; focused on acute care in a rural setting; limited to 1 institution and geographical area
Manias (2012) (Australia)	Naturalistic observation; individual interviews	RNs (N = 34) working in 2 geriatric evaluation and management units; 75 hours of observation	Patient language barriers and cognitive impairment; nurse–patient level of pain disagreement; inadequate staffing; reduced medication availability at night	Participants aware of being observed; RNs varied greatly in age and experience; 2-centre study limited to geographical area
Manias et al. (2005) (Australia)	Naturalistic observation; individual interviews	RNs (n = 52) and patients (n = 312) on 2 surgical units; 74 observations of 2 hours each	Delayed medication orders; lack of patient communication; increased ward activity led to decreased pain management	Patients aware of being observed; data collection took place on units in the same hospital
Martin et al. (2005) (Canada)	Focus groups	Community seniors (n = 8), nursing home residents (n = 4), informal caregivers (n = 8), nurses (n = 19), nursing home administrators (n = 6)	Lack of systematic medication protocols; lack of non-pharmacological remedies to treat multiple conditions; patient underreporting of pain	Small sample size for nursing home residents; recruitment of all health-care providers was through a provincial Alzheimer's organization

Namnabati et al. (2012) (Iran)	Individual interviews	RNs (*N* = 16) with 4–10 years' pediatric experience in a teaching hospital	Unstandardized medication administration protocols, pain documentation, and assessment tools; inadequate staffing; inappropriate pain reporting by children	Small sample size; participants practised solely in a pediatric setting; single-centre study also limited by geographical area
Older et al. (2010) (United Kingdom)	Individual interviews	Patients (*N* = 28) admitted for day surgery in a large district hospital	Patient inexperience with analgesic use; belief that combined medication use is unsafe; use of medication only when coping strategies failed	Participants had similar cultural and ethnic backgrounds; single-centre study also limited by geographical area
Rejeh et al. (2009) (Iran)	Individual interviews	RNs (*N* = 25) with surgical ward experience at a university-affiliated hospital	Lack of education; hospital policies limited nursing authority; workloads limited time for assessment and delayed medication	Research focus on practice of Iranian nurses; participants varied greatly in education level and years of practice; limited by geographical area
Stevens et al. (2011) (Canada)	Focus groups	Nurses and allied health professionals (*N* = 147); 16 focus groups	Limited prescribing privileges for nurses; lack of team cohesion; disregard for nurses' contribution to clinical decision-making	Purposive sampling and setting selection employed; participants practised solely in NICU

Quantitative Studies				
Broekmans et al. (2004) (Belgium)	Questionnaire	Randomized sample of university-employed nurses ($N = 312$) in surgery, medicine, oncology, ICU	Oncology nurses most positive towards opioid use; negative towards use of opioids in diagnostic phase; concerns about patient addiction	Sample comprised nurses from few departments; cross-sectional study may not account for confounding variables — that is, unit culture; limited to 1 institution and geographical area
Czarnecki et al. (2011) (United States)	Questionnaire	RNs ($N = 272$) from various departments of a children's hospital	Inadequate medication orders — pain management not prioritized; lack of time for premedication; parents reluctant to medicate children	Low response rate (28%); information on departments/ specialties of participants unavailable; limited to 1 institution and to pediatric population
Duke et al. (2013) (United States)	Questionnaire	Junior and senior nursing students ($n = 162$) and faculty ($n = 16$)	Knowledge positively correlated with education; poor behavioural pain assessment among students	Convenience sampling used; internal consistency of questionnaire was statistically low; limited to 1 postsecondary institution and 1 nursing program
Duignan & Dunn (2009) (Ireland)	Questionnaire	Emergency nurses ($N = 81$) in 5 emergency departments across 4 counties	83% had no training in pain management; poor pain assessment affected practice of 46% of nurses; inability to offer analgesics pre-diagnosis	Despite multi-location sampling, locations all governed by 1 regional health-care body
Kohr & Sawhney (2005) (Canada)	Questionnaire	APNs ($N = 116$) from a variety of patient care areas	Only 6% of nurses had pain management specialization; inadequate education of medical staff and patients	Majority (69%) of respondents from acute-care settings; disproportionate number of nurses surveyed from each specialty; limited to geographical area

Rose et al. (2012) (Canada)	Questionnaire	RNs ($N = 802$) with > 5 years' ICU experience from 12 Canadian nursing associations	Only 29% of nurses aware of clinical guidelines; inadequate use of behavioural pain assessment tools for uncommunicative patients; lack of pain score communication in handovers	Stratified, disproportionate sampling; self-report method may misalign reported and actual practice; limited to geographical area
Wang & Tsai (2010) (Taiwan)	Questionnaire	RNs ($N = 370$) from ICUs in 14 regional and district hospitals	Approximately 50% indicated poor pain knowledge; medication orders from physicians required	Majority (69%) of participants had not received formal pain management education prior to study; only portions of a validated survey tool were used in questionnaires; limited to geographical area
Mixed-Method Studies				
Breen et al. (2004) (United Kingdom)	Focus groups; questionnaire	GPs ($n = 3$), nurses ($n = 3$), patients with back pain ($n = 4$); questionnaire administered to 144 GPs	Mismatched patient–physician expectations; inadequate capacity to manage patients' multidimensional needs	Pilot study; participation inconsistent throughout study; limited to geographical area
Coker et al. (2010) (Canada)	Focus group; questionnaire/ survey tool	Focus groups: RNs ($n = 36$); survey respondents: nurses ($n = 115$)	Assessing pain in patients with impaired cognition; patients underreported pain; lack of time	Authors created survey tool used in the study — tool still requires external validation; limited to geographical area and care of elderly
He et al. (2010) (Singapore)	Educational intervention; questionnaire	RNs ($N = 108$) on surgical and medical children's wards in 2 public hospitals	Most frequently reported barriers: lack of time and lack of cooperation on the part of children and parents	Convenience sampling; study limited to female nurses; despite multi-centre recruitment, limited to geographical area

Individual Patient Barriers

This theme refers to unique patient characteristics, which were a central challenge to effective pain management. Negative patient attitudes and beliefs concerning pain medication and lack of patient involvement in care were particularly common. Inadequate patient communication, to the health professional, of pain experiences was highlighted and was especially prevalent in pediatric pain management.

Patient communication is critical to proper pain assessment, yet several of the studies report difficulty assessing pain among patients with compromised communication skills, such as sensory and cognitive impairment as seen in patients with dementia (Coker et al., 2010; Fox, Solomon, Raina, & Jadad, 2004; Manias, 2012; Martin, Williams, Hadjistavropoulos, Hadjistavropoulos, & Maclean, 2005). Similar challenges were observed in patients with language barriers, including infants and individuals whose first language was not English (Coker et al., 2010). Reduced patient communication in turn resulted in poor pain assessment by health professionals. Rose et al. (2012) found that nurses routinely preferred a 0–10 numerical rating self-report pain assessment tool and were significantly less likely to use behavioural assessment tools with nonverbal patients, thereby missing critical pain cues and experiences. Typically, behavioural pain assessment tools use nonverbal cues, such as facial expressions (frowning), vital signs (increased blood pressure), and particular behaviours (protecting of abdomen for abdominal pain), to objectively assess presence or severity of pain. Rose et al. (2012) found that the most common behavioural assessment tools used, as reported by critical care nurses ($N = 802$), were the Behavioral Pain Scale (Payen et al., 2001), the Adult Non-Verbal Pain Scale (Odhner, Wegman, Freeland, Steinmetz, & Ingersoll, 2003), and the Critical-Care Pain Observation Tool (Gélinas, Fillion, Puntillo, Viens, & Fortier, 2006). To compound inadequate patient communication, patient pain-related beliefs compromised communication of pain experiences. Using a focus group with nurses, Fox et al. (2004) found that nurses ($n = 27$) believed patients underreported pain out of fear of being perceived as "complainers" and disliked bothering staff for medication, possibly in an effort to be compliant patients. From survey responses ($n = 115$) and focus group discussions with nurses ($n = 36$), Coker et al. (2010) found that elderly patients in an acute-care setting primarily reported their pain to physicians. Given that other care providers, such as nurses, have more direct patient contact, it is evident that patient misunderstanding of health-care provider roles can negatively affect pain reporting.

Patients' attitudes towards analgesics can have an adverse effect on pain management. Older, Carr, and Layzell (2010) report that patients

(*N* = 28) admitted for day surgery used analgesics as a last resort when other coping strategies failed. These coping strategies included distraction methods and adoption of a positive attitude. Patients often compared their current pain with previous pain experiences to gauge their personal pain threshold. The same group of patients avoided pain medication, despite experiencing significant pain, due to an impression that combined analgesic use is unsafe. Other researchers have demonstrated that poor tolerance to side effects of pain medication, such as constipation and drowsiness, are attributable to reduced analgesic adherence (Coker et al., 2010; Martin et al., 2005).

Coupled with poor communication and a lack of adherence to pain medication, marginal patient involvement in pain care negatively affects pain management. Gregory and Waterman (2012) conducted naturalistic observations of five medical wards and found that patients did not express painful sensations unless specifically asked by physicians. The findings from interviews with physicians (*n* = 3), nurses (*n* = 3), and patients (*n* = 4) suggest that inadequate involvement in self-care is due in part to lack of access to local pain services and inadequate pain education (Breen, Carr, Mann, & Crossen-White, 2004). Patients expressed feeling highly vulnerable and functionally impaired by pain as they waited for referral to other health professionals or to chronic pain programs. At the same time, they were appreciative of knowledge and advice provided by chiropractors and osteopaths that helped to alleviate their pain. Breen, Austin, Campion-Smith, Carr, and Mann (2007) found that patients reported feelings of helplessness and powerlessness as they waited for referral. Interestingly, physicians who felt they were unable to help the patient also experienced these feelings. To increase patient engagement, physicians (*N* = 21) suggested multidisciplinary, small-group discussion-based education initiatives for patients.

In the pediatric population, interviews with nurses (*N* = 16) revealed that patient-specific variables, such as the expression of pain and the temperament and behaviour of the child, substantially influenced pain assessment and treatment (Namnabati, Abazari, & Talakoub, 2012). The role of parents and family in pediatric care may inadvertently hinder effective pain management. Namnabati et al. (2012) found that role expectations, age, and gender differences may impact pain reporting by children. For example, younger children are more reliant on their parents, which can increase pain reporting. In an educational intervention study with nurses (*N* = 108), children and parents failed to adhere to non-pharmacological pain interventions, impeding nurses' ability to effectively address children's post-operative pain (He et al., 2010). These interventions included breathing techniques, imagery and distraction, positive encouragement, thermal regulation, massage, and positioning/repositioning. A study by

Czarnecki et al. (2011) with nurses (N = 272) found parental resistance to pediatric pharmacological intervention, with parents concerned that their children would develop adverse side effects, tolerance, and addictions. Similar reasons underlying negative parental attitudes towards opioids and analgesics can be found in the literature (Fortier, Martin, Kain, & Tan, 2011; Rony, Fortier, Chorney, Perret, & Kain, 2010).

Professional Barriers

Barriers associated with professional knowledge and training formed the second theme. At an individual level, these included inadequate education and inappropriate attitudes and beliefs. At a team level, they related to a lack of interprofessional collaboration, with a strong interrelationship between professional and patient barriers. More specifically, if nurses do not have appropriate knowledge they may inadvertently endorse inappropriate attitudes and beliefs among patients, such as a belief that pain is a normal part of the aging process, thereby alluding to the unimportance of pain reporting and treatment in older populations. This notion is expanded upon in the discussion below surrounding the findings of Fox et al. (2004); Broekmans, Vanderschueren, Morlion, Kumar, and Evers (2004); and Martin et al. (2005).

Barriers were found to stem from the attitudes and beliefs of health professionals, leading to overly conservative pain management. Underlying professional misconceptions appeared to influence practice. These were related to opioids being dangerous, pain as a normal age-related phenomenon, decreased sensitivity to or inability to feel pain among older individuals and those with dementia, and the equating of absence of self-reported pain with absence of physical pain (Broekmans et al., 2004; Martin et al., 2005). In a survey of physicians (n = 6), nurses (n = 27), physiotherapists (n = 8), and health-care aides (n = 13), Fox et al. (2004) found that caregivers' insensitivity to pain experiences in the senior population resulted in undertreatment of pain. Others have identified disagreement between health-care providers' assessment of pain and patient-reported pain experiences as a prevalent barrier (Jablonski & Duke, 2012; Manias, 2012). Similar to patients, health professionals harboured concerns about addiction. In a study with university-employed nurses (N = 312), Broekmans et al. (2004) found that nurses were more compliant with opioid administration during the diagnostic phase of a condition, compared to later phases.

Martin et al. (2005) found that nurses cited a lack of education as a primary contributor to poor pain assessment. Rejeh, Ahmadi, Mohammadi, Kazemnejad, and Anoosheh (2009) found that nurses perceived a lack of education as the most prevalent barrier to sound clinical decision-making concerning pain; pain education was most likely to focus on pharmacological interventions — pharmacokinetics and safe-dose ranges of medications — underpreparing nurses for the various religious and cultural characteristics that clients can present with in practice. For example, historically, some religions believed that pain was required in the recovery of health and was experienced through the "will of God" (Unruh, 2007, p. 70). In patients belonging to cultures that value stoicism, the incidence and severity of pain may be underreported and even unexpressed, in contrast to patients belonging to cultures that value expressivity (Narayan, 2010). Nurses need to be knowledgeable about various religious and cultural beliefs with respect to pain in order to provide culturally competent and effective pain care.

Kohr and Sawhney (2005) surveyed advanced practice nurses (APNs) (N = 116) and found that 84% of respondents cited education as the primary barrier to proper pain care. In particular, difficulties occurred around the decision to prescribe and administer controlled-release opioids. Analgesic prescription requires comprehensive assessment and knowledge of how to individualize pain regimens for effectiveness. Controlled-release opioids require high levels of knowledge and experience in order to monitor and treat side effects, and practitioners were often concerned about its perceived increased capacity for abuse.

Related to education, nurses lacked clinical confidence in pain assessment and did not know how much pain was acceptable for patients to experience (Coker et al., 2010). Lack of pain education can perpetuate misinformed decision-making. Jablonski and Duke (2012) found that, when lacking proper education, professionals (N = 10) increasingly adhered to patient stereotypes (e.g., pain is an expected outcome of aging). Breen et al. (2004) also found mismatched expectations of pain experiences between patients and general practitioners, indicative of poor professional training in pain management. Duignan and Dunn (2009) surveyed emergency nurses (N = 81), to find that 83% had no formal training in pain management. Moreover, of the 802 Canadian nurses interviewed by Rose et al. (2012), only a third were aware of pain guidelines and policies at their place of employment. It would seem that appropriate education for nurses is lacking. Despite pain management competency following increased education, pain management remains substandard, as shown by Duke, Haas, Yarbrough, and Northam (2013) in their study with nursing students (n = 162) and faculty (n = 16). Duke et al. advocate for an evidence-based re-evaluation of current pain education initiatives.

At the team level, the absence of pain knowledge among medical team members not only hindered the implementation of effective pain management strategies but altered team dynamics. Nurses surveyed by Coker et al. (2010) stated that a primary barrier was physicians' lack of knowledge, experience, and skill in prescribing pain medication. They also cited a lack of documentation concerning pain assessment, inconsistent approaches to pain management, and the absence of collaboration between colleagues and members of other professions (Coker et al., 2010). This absence of collaboration often manifested as an inability to access clinical pain experts, reducing collaboration between pain experts and care providers in direct patient contact (Fox et al., 2004; Martin et al., 2005). Bergman (2012) and Wang and Tsai (2010) relate similar findings; in both studies, nurses reported that reliance on physician orders for pain care was a major barrier. In Wang and Tsai's (2010) study, nurses ($N = 370$) said that they should be able to design a pain care regimen for patients based on immediate postoperative assessments instead of having to wait for physician assessments and orders. Additionally, with only a small percentage of nurses choosing to specialize in pain management, pain care expertise was often lacking on medical teams (Kohr & Sawhney, 2005).

Organizational Barriers in Acute-Care Settings

Finally, effective pain management was burdened by a number of barriers associated with workplace dynamics, culture, and practices. These barriers were characterized by demanding workloads, a lack of time, and policies that negated optimal pain care. These organizational barriers limited health-care roles and the provision of effective pain management.

Demanding workloads among nurses and inadequate staffing have led to pain management being delivered by untrained personnel. For example, Corazzini et al. (2013) found that several long-term-care facilities ($N = 10$) primarily relied on licensed practical nurses (LPNs) and nursing attendants to assess and manage pain; yet, in general, LPNs are not trained or licensed to provide comprehensive pain assessment and make medication decisions. In other instances, the high-volume work environment forced nurses to multitask, leaving little time for pain assessment (Czarnecki et al., 2011; He et al., 2010; Rejeh et al., 2009). Upon observing nurses ($n = 18$) in the practice setting, Gregory and Waterman (2012) found that when nurses were providing direct patient care they were often involved in a secondary activity; this prevented patients from freely discussing health concerns or pain experiences with them. As well, nurses faced several interruptions in care, creating opportunities for errors in medication administration.

In addition to prioritizing high volumes of work, nurses were burdened by inadequate pain documentation protocols and poor unit strategies for procuring pain medication efficiently. In a study by Namnabati et al. (2012), pediatric nurses cited a lack of standardized pain assessment tools and analgesic administration protocols as two of the most prevalent barriers to pain management. Observations of nurses (*n* = 52) and patients (*n* = 312) by Manias, Bucknall, and Botti (2005) echo these findings and found that delayed medication orders by physicians further complicated matters. Though nurses strived to manage pain in a timely manner, their active interventions were often delayed by the need to contact a physician to obtain new or modified medication orders (Manias et al., 2005). Nurses (*N* = 34) were also observed to rely on patients' ability to tolerate pain during night shifts, increasing the incidence of pain, due to policies requiring physicians to decrease analgesic orders at night (Manias, 2012). Thus, nurses' limited prescribing privileges was common to a number of studies, and a central challenge to analgesic administration (Duignan & Dunn, 2009; Manias, 2012; Stevens et al., 2011).

At the team level, policies limiting professional autonomy in medical decision-making among nurses have created significant challenges in pain management. Qualitative exploration with nurses by Stevens et al. (2011) (*N* = 147) and Bergman (2012) (*N* = 15) both reveal a lack of medical team cohesion and the presence of established hierarchical relationships, which undermine nurses' contribution to clinical decision-making. Interviews with nurses (*N* = 25) by Rejeh et al. (2009) further show that nurses' limited authority in pain assessment and management negatively impacts their relationship with patients. Jablonksi and Duke (2012) also allude to authoritative boundaries, where frontline care providers cited a limited scope of practice compared to physicians and poor team cohesion led to decreased communication at vital points in the care transition. According to a Canada-wide study by Rose et al. (2012), which surveyed over a thousand intensive care nurses through all provincial regulating bodies, only 60% of pain communication occurs during shift change reports. These findings suggest the need for increased nursing leadership on medical teams. Qualitative inquiry into leadership in chronic pain management programs reveals that nursing leadership impacts pain management at the team level as well as at the organizational level. In a study by Dysvik and Furnes (2012), leaders of multidisciplinary teams perceived that nursing leadership impacts care at the team level, specifically through the skill of nursing leaders in selecting individuals who complement the workplace culture and team and are attuned to the care needs of the patient population. Effective nursing leadership at the organizational level, similarly, takes the form of selecting complementary health-care team members who possess the personal characteristics and interaction traits necessary to form competent, skilled teams with a well-defined, cohesive vision. The nurses interviewed (*n* = 9) cited the critical importance of awareness of each team member's competency in managing chronic pain (Dysvik & Furnes, 2012).

Discussion

The purpose of this integrative review was to consolidate the current research on barriers to pain management and determine the gaps in the research. Nurses have a pivotal role to play in the management of pain and it is evident that there are patient, professional, and organizational barriers to effective pain management practices. While these themes are not new (Fox et al., 2004), our review adds insight into the complexities and interrelatedness of the barriers. We propose that these findings offer an opportunity to inform new perspectives and research endeavours. Our discussion focuses on three important areas: the role of the nurse, pain education as a public health initiative, and directions for future research. The strengths and weaknesses of the review and conclusion follow.

The Role of the Nurse in Pain Management

Nurses have long been recognized as central to the integrity of good pain management. The role of nursing is primarily to assess patient pain; monitor the effectiveness and accordingly change pain regimens to mirror pain status; monitor and manage adverse effects, patient ADLs, and bowel function; and communicate patient satisfaction to the health-care team (Sawhney & Sawyer, 2008). Yet nurses, along with other health professionals, have also been part of the problem. Explicit challenges include a lack of practice agreements and prescriptive authority, inadequate consultation resources for patients outside of the acute-care setting, and inexperience in managing patients with complex conditions (Sawhney & Sawyer, 2008). Though the importance of pain education at the undergraduate nursing level is essential, the interrelatedness and complexity of the barriers highlight professional opportunities for APNs, which the Canadian Nurses Association defines as nurses with advanced skills and knowledge. In Canada, the clinical nurse specialist (Canadian Nurses Association [CNA], 2009a) and the nurse practitioner (CNA, 2009b) are the two recognized APN roles. APNs have long been involved in pain management and our review highlights key components of the APN role. In particular, there is a clear need for expertise in education (Bryant-Lukosius, DiCenso, Browne, & Pinelli, 2004), interprofessional relationships (Kaasalainen et al., 2010), and prescribing (Stenner & Courtenay, 2008) in order to raise the quality of care. Timely, effective pain control would be enhanced if the range of qualified prescribers were to be enlarged. In Canada, changes in federal legislation removed some barriers to the ability of nurse practitioners (NPs) to prescribe controlled substances (Government of Canada, 1996). While changes in provincial laws and regulations are still needed to facilitate NPs' use of the full formulary, allowing NPs with pain expertise to prescribe to full scope could address a number of the barriers identified in this review. A survey of NPs in British Columbia found that 85% would incorporate the prescribing of narcotic and controlled drugs, if permitted, into their practice (College of Registered Nurses of British Columbia, 2013). For such changes, nurses need to participate or take a lead role in developing and contributing to local and national policy (Furlong & Smith, 2005). However, it is acknowledged that the implementation of their role is complex (Sangster-Gormley, Martin-Misener, Downe-Wamboldt, & DiCenso, 2011). Further work is required to more fully understand these roles and the contribution they are making to pain management within nursing.

Pain Education as a Public Health Initiative

The review has identified the interrelatedness of many of these barriers, with inadequate education being a significant patient and professional barrier. Systematic reviews of patient education with respect to pain are disappointing, with several failing to demonstrate an impact on pain reduction or prevention (Demoulin et al., 2012; Louw, Diener, Butler, & Puentedura, 2013; Ronco, Iona, Fabbro, Bulfone, & Palese, 2012). The content of the education is important. There have been calls for education that moves towards patient empowerment (Johansson, Nuutila, Virtanen, Katajisto, & Salanterä, 2005) and that includes pain science (Louw et al., 2013). An individualized and patient-centred approach has also been highlighted as important for effective pain management, in particular for older adults with dementia (Newton, Reeves, West, & Schofield, 2014) and children undergoing tonsillectomy (Howard et al., 2014). Nurse-led educational interventions using a patient-centred approach have been found to be moderately effective in reducing cancer pain (Martinez et al., 2014). It is particularly salient to address the misconceptions or concerns a patient or family may have regarding pain and pain management interventions, such as the fear of addiction.

The above findings suggest that vulnerable populations, especially, may benefit from individualized patient-centred pain education approaches. We have an opportunity to reconsider the delivery of patient education and reframe it in a public health context. Public health takes a population focus, which uses all organized measures to prevent disease, promote health, and prolong life (World Health Organization, 2014). Thus public health is concerned with the total system, not only the eradication of a particular disease. Positioning pain as a public health concern could serve to improve public education with regard to the deleterious effects of acute pain and the development of chronic or persistent pain (Kehlet, Jensen, & Woolf, 2006). The emphasis on education and on relationship-centred care is embodied in the professional practice model and standards of practice for community practice nurses (Community Health

Nurses of Canada [CHNC], 2011). The explicit expectation that the nurse–client relationship will promote participation by the individual, family, community, and population (CHNC, 2011) places nurses in an ideal position to facilitate pain education. In Europe there have already been calls for a public health approach to chronic non-cancer and cancer pain (Hanna, 2012). This is particularly fitting for pain management, where education can encompass patient, professional, and organizational aspects in a coherent manner by recognizing their interrelatedness.

We also have opportunities to strengthen the synergy between patient education and organizational change to inform national initiatives. In Canada, the partnership between the Canadian Pain Society and the Canadian Pain Coalition, which is a patient organization, has resulted in the Canadian Pain Summit (Canadian Pain Society, 2013). The need for a national pain strategy in Canada has been recognized, a strategy that specifically identifies educational, clinical, and research needs (Lynch, 2011). A national pain strategy will provide the impetus needed to develop a coordinated approach by education, research, and health institutions across the provinces. Such a strategy could improve the lives of many experiencing needless pain.

Directions for Future Research

While this review has identified quantitative and qualitative research approaches, few of the studies provide insight into the contextual complexities of everyday practice. Ethnography, situated in the naturalistic science paradigm, provides a means to study the cultural context of everyday practice by integrating the complexities of information and relationships to inductively generate functional associations (Benjamin, 2005). In our review, just three studies used naturalistic observation in their research design. These were conducted in a hospital setting and observed 18 to 52 registered nurses over 38 to 150 hours. Two of the three focused on both nurses and patients. The importance of understanding context using ethnography in pain research has been highlighted (Lauzon-Clabo, 2007; Manias, Botti, & Bucknall, 2002; Manias, Bucknall, & Botti, 2004), yet such studies remain a minority. Institutional ethnography, with its focus on uncovering the social organization of knowledge, as seminally detailed by Smith (1987), by studying the social interactions of people within a matrix of interconnected social processes, could be enlightening (Campbell & Gregor, 2002; Rankin & Campbell, 2009). Understanding the contextual factors known to influence knowledge translation (Estabrooks, Squires, Cummings, Teare, & Norton, 2009) could lead to the identification of interventions and opportunities for improving care.

The review has also identified a lack of quantitative evaluative studies — that is, randomized control trials (RCTs) — perhaps highlighting the complexities and challenges of this area. While there is a need for further RCTs, a lack of contextual understanding may limit the realistic implementation of knowledge and improvement in the clinical setting. It has been noted that quantitative research methods are not as well suited for measuring organizational change, leadership of guideline implementation, and quality of patient care (Curry, Nembhard, & Bradley, 2009). All are important outcomes for improving pain management. Pragmatic approaches, utilizing mixed methods, could offer realistic evaluations that are contextually sensitive. A mixed-method paradigm draws on complementary functions of quantitative and qualitative research methods to uncover the complexities of pain management practices, as classically detailed by Jick (1979). Mixed methods have been used successfully in pain research (Carr, Brockbank, Allen, & Strike, 2006; Gagliese et al., 2009; Twycross & Finley, 2013).

The majority of the studies were limited by having been conducted at a single site or geographical location, with just two of the studies extending data collection to the provincial level in Canada. There were no nationwide or international studies.

Strengths and Limitations of the Review

This integrative review consolidates findings from original research articles to elucidate barriers to effective pain management and identify gaps in research and policy. The literature is large and spans many years, and because we wanted to focus on current practice, our search used a 10-year timeframe (2003–13). A diverse range of publications describing the current gaps in literature, policy, and practice with respect to pain management were identified. However, only original research articles were included in the data analysis and synthesis. Grey literature was used to further support our findings.

We acknowledge that our review is limited considering that the search strategy restricted articles to those published in English. Thus, it is possible that some original research articles and secondary sources of information were missed. In addition, while international literature was used in the review, it was interpreted to align with the Canadian context.

Moreover, we did not include a quality assessment of studies, in keeping with Whittemore and Knafl (2005). While it is possible that some of the included studies lacked scientific rigour, there is considerable consistency across the findings. We believe that a quality assessment could have precluded us from capturing relevant literature sufficient to fully explore the depth and breadth of our topic. Lastly, we acknowledge that the dearth of intervention studies identified through our search strategy may be a result of not specifically consulting databases for registered controlled trials, such as the Cochrane Central Register of Controlled Trials database. However, such trials would be unlikely to elicit meaningful interventions related to the complexity of pain management in the clinical setting, and this approach was not commensurate with the integrative review methodology advocated by Torraco (2005) and by Whittemore and Knafl (2005). Our search strategy targeted nursing-specific databases.

Conclusion

This integrative review has identified a significant body of literature describing patient, professional, and organizational barriers to pain management. It has also identified the complexities and interrelatedness of these barriers and makes several suggestions for future research that could bridge some of the gaps and improve pain care. There is a wide gap in the patient/public understanding of pain management, and this appears to play a central role in the quality of nurse–patient interactions. Related to this is the compelling ongoing evidence of shortfalls in the educational preparation of nurses regarding pain management. While initiatives to improve this situation continue, there is little to suggest that significant change is imminent. New approaches, such as harnessing the patient's voice through public education, may be an additional lever for change. Reframing pain education as a public health initiative could offer a compelling opportunity for sustainable improvement, as could strengthening partnerships between patients and health-care providers.

In Canada and in other countries where nurses are able to prescribe medications, including analgesics (and particularly opioids), there are tremendous opportunities for the APN to take a leadership role in pain management. Nurses can also play a leadership role in sound pain policies at the institutional level and can mitigate many of the organizational barriers. Nurse leaders who advocate for improved pain management need a stronger and more persistent voice.

Finally, research approaches such as institutional ethnography and pragmatic mixed methods, which provide contextual understanding of how pain is managed, are recommended. Research to evaluate organizational interventions would be particularly important, as it is conducted across provinces/states rather than in one geographical location. The delivery of high-quality care that encompasses effective pain management strategies must be a priority for nursing.

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Disclosure: None of the authors has any conflicts of interest or research financial statements to disclose.

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CJNR 2014, Vol. 46 Nº 3, 94–109

Male RNs: Work Factors Influencing Job Satisfaction and Intention to Stay in the Profession

**Dale Rajacich, Debbie Kane, Kathryn Lafreniere,
Michelle Freeman, Sheila Cameron, James Daabous**

Males represent approximately 6.8% of registered nurses in Canada and consequently constitute an untapped health workforce resource. The authors investigated environmental work factors in the acute-care setting and their influence on male RNs' job satisfaction and intention to stay in the profession. They conducted a cross-sectional study of male RNs employed in acute-care settings in the province of Ontario. Correlations and multiple regression analyses were used to examine career satisfaction and intentions. Nurses who were most satisfied with their career valued extrinsic rewards (pay, vacation, and benefits), control and responsibility, and opportunities for professional development; those who were least satisfied and voiced their intention to leave the profession tended to work part time, experience gender mistreatment, and be dissatisfied with extrinsic awards, scheduling, and organizational support. A unique finding of this study relates to the significant predictive relationship between gender mistreatment and males' intention to leave.

Keywords: job satisfaction, retention, male RNs, acute care

Résumé

Le personnel infirmier masculin : facteurs reliés au travail influant sur le degré de satisfaction professionnelle et l'intention de demeurer dans la profession

Dale Rajacich, Debbie Kane, Kathryn Lafreniere, Michelle Freeman, Sheila Cameron, James Daabous

La profession infirmière compte environ 6,8 pour cent d'hommes au Canada, une main-d'œuvre qui constitue une ressource inutilisée dans le domaine de la santé. Les auteurs ont examiné les facteurs environnementaux reliés au travail dans des services de soins actifs et l'influence qu'ils exercent sur le degré de satisfaction professionnelle chez les infirmiers ainsi que leur intention de demeurer dans la profession. Dans le cadre d'une étude de prévalence chez les infirmiers œuvrant dans des services de soins actifs dans la province de l'Ontario, des corrélations ont été établies et des analyses de régressions multiples ont été réalisées. Les infirmiers dont le degré de satisfaction était le plus élevé accordaient une importance aux récompenses extrinsèques (traitements salariaux, vacances, avantages sociaux), au degré de contrôle et de responsabilité et aux possibilités de développement professionnel. Ceux qui étaient les moins satisfaits et qui ont exprimé leur intention de quitter la profession travaillaient surtout à temps partiel, vivaient des mauvais traitements à caractère sexiste et éprouvaient de l'insatisfaction concernant les récompenses extrinsèques, les horaires et le soutien organisationnel. Cette étude a révélé l'existence d'un important lien prédictif entre les mauvais traitements à caractère sexiste et l'intention des infirmiers de quitter la profession.

Mots clés : satisfaction professionnelle, infirmiers, soins actifs, mauvais traitements à caractère sexiste

It is anticipated that almost 60,000 full time equivalents (FTEs) will be required in Canadian nursing by 2022 (Tomblin Murphy et al., 2009). This impending shortage is related to several factors, including a lack of investment in the nursing profession in developed countries, an aging workforce, and the increasing demand for RNs to address the health-care needs of growing and aging populations (Institute of Medicine, 2010). In addition, both recruitment and retention of male RNs has proved to be a challenge for the profession and males remain an elusive and untapped health workforce resource in many countries. In 2010, males represented only 6.8% of Canadian registered nurses (Canadian Institute for Health Information, 2012), indicating that nursing has yet to break the gender barriers that other professions have been successful in addressing (Sherrod, Sherrod, & Rasch, 2006). Although retention in the nursing profession has been found to be an issue among both men and women, males are reported to leave the profession at higher rates and, according to several studies (Curtis, Robinson, & Netten, 2009; Sochalski, 2002), for different reasons compared to their female counterparts. It is essential to understand which work factors are valued by male nurses so that focused retention strategies can be implemented.[1]

Background

A US study using data from the quadrennial National Sample Survey of Registered Nurses (NSSRN) found male RNs to be less satisfied in nursing regardless of setting or position; this difference was consistent across years of experience as well as for RNs in advanced practice roles such as nurse practitioners and nurse anesthetists (Sochalski, 2002). Rajapaksa and Rothstein (2009) completed a secondary analysis of the NSSRN 2000 survey and found that males and females were equally likely to cite opportunities for a more rewarding professional position and better hours as reasons for leaving nursing; however, males were found to be more likely to also cite salary. The authors suggest that male nurses attach greater importance to earnings because of their traditional role as breadwinner in the family and because they hold expectations for a higher salary regardless of the nature of the work. Rambur, Palumbo, McIntosh, Cohen, and Naud (2011) found that males were no more likely than females to leave their position (23% vs. 20%) and that gender was not a predictor of intention to leave. However, among those intending to leave, males were more likely than females to be doing so for reasons related to "job dissatisfaction" (75% vs. 51%). Among dissatisfied nurses, the issue most often cited by males was "dissatisfaction with salary."

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[1] In this article, the word "gender" will be used in referring to self-identification as male.

Borkowski, Amannm, Song, and Weiss (2007) surveyed 284 male RNs, almost half (46%) of whom reported that they were considering leaving the nursing profession. No significant difference was found between males and females for intention to leave, but a significant difference was found for what they identified as important for retention; more male than female RNs identified "benefits" as an important factor. Flinkman, Leino-Kilpi, and Salantera (2010) found that being younger, more highly qualified, or male was associated with greater intention to leave (p. 1428).

The relatively short work life of a nurse has important implications for maintaining a qualified workforce. In the United Kingdom, Curtis et al. (2009) compared general census household data for the years 1991 and 2001 to estimate the length of a nurse's work life. During the 10-year period, the expected work life of males decreased by 9 years whereas that of females decreased by only 1 year. Reasons cited by males for leaving the profession included opportunities for less demanding work, dissatisfaction with salaries, and decreased opportunity for vertical progression because of health-care restructuring. Males also stated that an unhealthy work environment, including social isolation, violence, aggression, and discrimination, affected their job satisfaction. Burnett (2007) found that 44% ($n = 20$) of male RNs experienced discrimination as a result of their gender and 31% ($n = 14$) experienced social isolation. In a national survey of Canadian RNs in rural and remote areas, males were more likely than females to report having recently experienced the threat of sexual assault, emotional abuse, verbal or sexual harassment, or a sexual assault while at work (Andrews, Stewart, Morgan, & D'Arcy, 2012).

In summary, there are mixed results as to why men leave the nursing profession. If we are to build a strong resource pool reflective of our gendered society, it is critical that we further explore male RNs' job satisfaction as well as their intention to leave. The purpose of this study was to examine environmental factors in the acute-care setting and their influence on job satisfaction and intention to stay in the profession among male RNs in Canada.

The research questions were as follows: 1. *To what degree are environmental work factors related to male RNs' satisfaction in acute-care hospitals and their intention to remain in or leave the profession?* 2. *What are the most influential predictors of male RNs' career satisfaction and their intention to leave?*

Method

Sample

This cross-sectional, correlational study was approved by the research ethics board at the University of Windsor.

Questionnaires were mailed to a random sample of 1,300 male nurses working in acute-care settings across the province of Ontario. The names and contact details for the sample were obtained from the College of Nurses of Ontario, based on members who self-identified as male. Consent was implied with the return of the questionnaire. Eight questionnaires were returned unopened because the recipient was no longer at the address. A reminder postcard was sent to all nurses 6 weeks after the initial mailing. A total of 382 completed questionnaires were returned, yielding an overall response rate of 29.6%. Demographics are included in the Results section.

Procedure and Measures

The questionnaire took approximately 45 minutes to complete. It contained detailed demographic items regarding workplace characteristics (e.g., years employed as a nurse, years in current hospital, hospital unit, part-time/full-time status) and personal background information. The questionnaire included several measures: the McCloskey and Mueller Satisfaction Scale (MMSS) and scales measuring Professional Development Opportunities, Perceived Organizational Support, Intention to Leave, Career Satisfaction, and Gender Mistreatment.

Space was provided for respondents to write comments. The package comprised an informed consent letter, the questionnaire, and a postage-paid return envelope.

The MMSS (Mueller & McCloskey, 1990) is a 31-item multidimensional questionnaire that measures nurses' job satisfaction using a five-point scale from *very dissatisfied* (1) to *very satisfied* (5). Eight work factors were assessed: extrinsic rewards (pay, vacation, and benefits), scheduling satisfaction, family/work balance, co-workers, interaction, professional opportunities, praise/recognition, and control/responsibility. Internal consistency/reliability of the MMSS total was found to be strong in the present study (Cronbach's alpha = .88) and MMSS subscales also showed adequate internal consistency, with alpha coefficients ranging from .71 to .83.

Perceived Organizational Support (Eisenberger, Huntington, Hutchison, & Sowa, 1986) is an eight-item scale used to measure hospital support using a five-point scale, from *strongly agree* to *strongly disagree*. Strong internal consistency reliability was found for this measure (Cronbach's alpha = .92). Sample item: "This hospital cares about my opinions."

The Intention to Leave Scale, adapted from Cammann, Fichman, Jenkins, and Klesh (1983), comprises three items (Cronbach's alpha = .79) and uses a five-point scale, from *strongly agree* to *strongly disagree*. Sample item: "I am seriously considering quitting my job."

Career Satisfaction was assessed using the Career Satisfaction Scale developed by Greenhaus, Parasuraman, and Wormley (1990). This scale comprises five items (Cronbach's alpha = .89) and uses a five-point scale, from *strongly agree* to *strongly disagree.* Sample item: "I am satisfied with the success I have achieved in my career."

The Professional Development Opportunities Scale, developed for our past research (Cameron, Armstrong-Stassen, Rajacich, & Freeman, 2010), includes nine items (Cronbach's alpha = .90) on professional development opportunities available to nurses for skill development, educational advancement, and professional development. Items are measured on a five-point scale, from *very satisfied* to *not at all satisfied.* Sample item: "How satisfied are you with how well your hospital provided release time to pursue further education."

The Gender Mistreatment Scale was developed by the investigators for the present study and includes three items (Cronbach's alpha = .76): "At work, how often have you experienced unfair treatment due to your gender?" "I feel my workplace contributions are not valued because I am a man." "How often have you experienced sexual orientation stereotyping (i.e., assumed you were gay) as a male in nursing?" Participants responded on a five-point scale, from *never* to *very often.*

Results

Participants ranged in age from 24 to 74 years, with a mean age of 44. The majority were heterosexual (86.4%), were married (65.3%), and gave their ethnicity as White/European/Canadian (69.1%). The majority were diploma-prepared (48.7% with an RN college diploma and 3.2% with an RN hospital-based diploma), while 36.8% had a baccalaureate in nursing. Participants had been employed as a nurse for 16.0 years on average and had worked at their current hospital for 11.5 years on average. The majority of participants were full-time permanent employees (80.2%), worked in direct patient care (91.9%), and were members of a union (88.4%).

Environmental Work Factors Associated With Male RNs' Satisfaction and Intention to Leave

To address the first research question, we initially examined descriptive statistics for the MMSS and its subscales, as well as for all of the other measures. Scale means, rather than totals, are reported in order to permit comparison of our findings with scale means of previous research. In general, our participants showed levels of satisfaction in the mid- to higher range on the MMSS and its subscales (i.e., ranging from 2.88 to 3.72 on a 5-point scale), and reported highest satisfaction with

Interaction Opportunities (*M* = 3.72) and lowest satisfaction with Control and Responsibility (*M* = 2.88). They expressed high levels of Career Satisfaction (*M* = 3.46) and moderate levels of Professional Development Opportunities (*M* = 2.49) and Perceived Organizational Support (*M* = 2.64). They also expressed moderate levels of perceived Gender Mistreatment (*M* = 2.45) and Intention to Leave (*M* = 2.50).

Correlations, *t* tests, and one-way analyses of variance were then conducted to explore the influence of environmental work factors (i.e., background and workplace characteristics) on the workplace variables (MMSS and its subscales as well as Perceived Organizational Support, Professional Development Opportunities, Career Satisfaction, Gender Mistreatment, and Intention to Leave). Age was found to be unrelated to any of the outcome measures. Participants who identified as gay had higher levels of MMSS Total Satisfaction, t (366) = –2.51, p = .012, and Scheduling Satisfaction, t (362) = –3.07, p = .002, than those who identified as heterosexual. Participants who had a baccalaureate in nursing reported significantly higher levels of Perceived Organizational Support, t (322) = –1.97, p = .049, than those with an RN diploma.

Number of years employed as a nurse was found to be significantly and positively associated with MMSS Extrinsic Rewards, r (372) = .10, p = .042. Number of years employed at one's current hospital was positively associated with Total Satisfaction on the MMSS, r (371) = .15, p = .003; Extrinsic Rewards, r (370) = .17, p = .001; Scheduling, r (370) = .11, p = .03; Interaction Opportunities, r (372) = .13, p = .011; and Professional Opportunities, r (369) = .13, p = .015. There was a negative relationship between number of years at one's current hospital and Intention to Leave r (375) = –.15, p = .003, indicating that nurses who had been employed longer at their current hospital were less inclined to report that they intended to leave.

To assess the impact of hospital unit on the outcome variables, we conducted a series of one-way analyses of variance comparing the five most commonly identified units (medical/surgical, emergency room, intensive care/coronary care, operating room/recovery, and psychiatry). Only the MMSS Scheduling Satisfaction outcome measure showed significant differences by hospital unit, F (4, 298) = 3.16, p = .014. Post hoc comparisons (Tukey's HSD) revealed that Scheduling Satisfaction was significantly higher for nurses working in the operating room (*M* = 3.35, *SD* = .91; p = .039) or on medical/surgical units (*M* = 3.22, *SD* = .85; p = .033) than for those working in intensive care/coronary care (*M* = 2.83, *SD* = .83).

Full-time permanent employees were compared to part-time permanent employees in a series of independent *t* tests. Full-time employees scored significantly higher on the MMSS subscales Interaction Opportunities, t (347) = 2.10, p = .037; Professional Opportunities, t (345) = 2.11, p = .036; and Praise and Recognition, t (347) = 2.26, p = .025. Part-time permanent employees showed significantly greater intention to leave than full-time employees, t (351) = –2.38, p = .018.

Nurses who were not members of a union showed significantly higher levels of MMSS Control and Responsibility, t (373) = 2.39, p = .017; Professional Development Opportunities, t (377) = 2.17, p = .030; and Perceived Organizational Support, t (377) = 2.52, p = .012, than those who were members of a union. There was a significantly higher representation of nurses engaged in management/administration in the non-union group, $\chi^2(3, N = 379) = 20.92, p < .001$.

Predictors of Career Satisfaction and Intention to Leave: Regression Findings

To address our second research question, we conducted a series of standard multiple regression analyses with Career Satisfaction and Intention to Leave as outcome measures. Number of years at one's current hospital, MMSS subscales, Perceived Organizational Support, Professional Development Opportunities, and Gender Mistreatment were included as potential predictor variables. We first examined the pattern of intercorrelations among predictors and outcome measures, and included as predictors only those variables that were significantly correlated with a particular outcome measure. The highest correlation between predictor variables was r (375) = .63, p < .001, between MMSS Control and Responsibility and Professional Development Opportunities, and examination of collinearity diagnostics indicated no problems with multicollinearity in either of the regression models. Significant predictors in the final regression models for each of our two outcome measures are displayed in Table 1.

The overall regression model for Career Satisfaction was significant, R^2 *(adj)* = .33, $F(4, 369) = 46.58, p < .001$. Examination of the beta coefficients and squared semi-partial correlation coefficients displayed in Table 1 indicates that MMSS Extrinsic Rewards, MMSS Control and Responsibility, and Professional Development Opportunities were all significant, positive predictors of Career Satisfaction, with Extrinsic Rewards accounting for 7% of the unique variance in this outcome variable, while Control and Responsibility and Professional Development Opportunities accounted for an additional 2% and 1%, respectively, of the unique variance. Nurses who reported greater satisfaction with their extrinsic rewards and their degree of control and responsibility at work, and who perceived that their workplace afforded them opportunities for professional development, were more likely to express higher levels of overall career satisfaction.

Table 1 ***Significant Predictors of Career Satisfaction and Intention to Leave***

Outcome Variable	**Predictor Variables**	β	*t*	sr^2
Career satisfaction	MMSS[a] – extrinsic rewards	.28	6.18***	.07
	MMSS – control and responsibility	.21	3.25**	.02
	Professional development opportunities	.16	2.77**	.01
Intention to leave	MMSS – extrinsic rewards	-.15	3.14**	.02
	Gender mistreatment	.14	3.12**	.02
	Perceived organizational support	-.20	-3.00**	.02
	MMSS – scheduling	-.12	-2.25*	.01

[a] MMSS = McCloskey and Mueller Satisfaction Scale
* $p < .05$, ** $p < .01$, *** $p < .001$

The regression model for Intention to Leave was also significant, R^2 *(adj)* = .37, $F(10,354) = 22.73$, $p < .001$. As shown in Table 1, MMSS Extrinsic Rewards, Perceived Organizational Support, and MMSS Scheduling were all significant negative predictors of intention to leave, accounting for 2%, 2%, and 1%, respectively, of the unique variance in this outcome variable. Nurses who were less satisfied with their extrinsic rewards and scheduling, and who perceived less support from their hospital, were more likely to express intention to leave. Gender Mistreatment emerged as a significant positive predictor of Intention to Leave, accounting for 2% of the unique variance. Individuals who reported a higher degree of gender mistreatment were more likely to express a desire to leave their job.

At the end of the questionnaire, participants had the option of making comments. Content analysis revealed two prominent themes. Decreased work satisfaction ($n = 64$) and gender mistreatment ($n = 36$) were the most frequently expressed concerns. As reflected in the following statements, there was general dissatisfaction related to the impact of budget cuts on nurses' ability to provide quality care to their patients: "Excessive non-nursing functions assigned to nursing, with no increase in staff." "I believe my current facility is run on the basis of a financial model and directly conflicts with my philosophy of patient-centered care. This has led to a huge disconnect between administration and general staff, leading to a poor environment overall."

Interestingly, the second prominent theme, gender mistreatment, was expressed from a range of perspectives. Participants stated that gender resulted in their being given the heaviest and most violent patients to care for: "male nurses are assigned difficult combative patients at risk of violence in code white [violent patient alert] situations"; "one comment that comes up a lot at work is I need your muscles"; "as a male RN you are sought out quite often for very heavy transfers and lifts." While a few participants felt that they received more respect due to their gender — "At times physicians will listen to a male over a female's suggestion" — another stated, "Our work is more closely scrutinized than [that of] our female counterparts."

Discussion

The male RNs in our study were moderately satisfied with extrinsic rewards, scheduling, interaction opportunities, and praise and recognition, and slightly less satisfied with professional opportunities and sense of control and responsibility. They were ambivalent about hospital support (neither satisfied nor dissatisfied). Those who were the most satisfied with their careers valued extrinsic rewards, control and responsibility, and opportunities for professional development; those who were least satisfied and voiced their intention to leave the profession tended to work part time, experience gender mistreatment, and express dissatisfaction with extrinsic rewards, scheduling, and organizational support.

Work Factors, Job Satisfaction, and Intention to Leave

Male RNs who had been employed the longest were significantly more satisfied with environmental work factors, including salary, benefits, vacation, scheduling, interaction opportunities, and professional opportunities. Bjork, Samdal, Hensen, Torstad, and Hamilton (2007) found that both male and female RNs who had been employed longer in their current position were more satisfied than their counterparts who had worked for a shorter period; consistent with the impact on job satisfaction, male RNs who had been employed the longest were significantly less likely to express intention to leave their current job, while extrinsic rewards was a significant negative predictor of intention to leave. Studies have found that male RNs are more influenced than female RNs by extrinsic rewards in terms of intention to stay in the profession (Borkowski et al., 2007; Buffington, Zwink, Fink, DeVine, & Sanders, 2012). Rajapaksa and Rothstein (2009), in a study with nurses who had left the profession, found that male RNs were 2.5 times more likely than female RNs to state that they had left nursing for a higher salary. While budget cuts and financial restraints may limit management's ability to raise salaries, there are other benefits, such as workplace wellness programs, that management might consider adopting to attract and retain valued employees (Baicker, Cutler, & Zirui, 2010). In our study, full-time employees were significantly more satisfied with interaction opportunities, professional opportunities, and praise and recognition.

The Registered Nurses' Association of Ontario has been lobbying the provincial government to increase its complement of full-time RNs until the goal of 70% full-time nurses has been met. Significant gains were noted between 2004 and 2008, and in 2010 65.8% of all RNs in Ontario were reported to be employed full time. However, there was a loss of full-time positions over the subsequent 2 years (Registered Nurses' Association of Ontario, 2012). This could negatively impact the retention of male nurses in the profession, since male RNs, in particular, value full-time employment and its associated benefits (Borkowski et al., 2007).

In our study, the only job satisfaction subscale that was significantly related to hospital unit was scheduling satisfaction for nurses working in the operating room or in a medical/surgical unit. The findings have been inconsistent in the limited previous research related to job satisfaction and type of unit worked. Boyle, Miller, Gajewski, Hart, and Dunton (2006) found that nurses in pediatric, rehabilitation, and outpatient units were more satisfied than those in emergency and surgical units, while Davis, Ward, Woodall, Shultz, and Davis (2007) found no difference between nurses working in medical/surgical and critical care units. Klaus, Ekerdt, and Gajewski (2012) found that nurses working in medical/surgical units were the most satisfied. The lack of a clear relationship between type of unit and job satisfaction may be due to multiple variables, such as staffing, patient acuity, type of scheduling, whether the nurse is working in his or her unit of choice, and managerial support.

In our study, a difference was found between unionized and non-unionized nurses in terms of satisfaction. The non-unionized RNs tended to have management roles and to perceive that they had more support, control and responsibility, and professional development opportunities. However, the non-management sample size was small, since most hospital employees in Ontario are unionized and the majority of participants (88%) in the study belonged to a union. Unionized environments have the potential to create a "them versus us" mentality, with "them" representing management and "us" representing staff. Different benefits and roles (union vs. non-union) associated with these positions impact professional development opportunities and the divide between union and non-union RNs.

A supportive work environment was found to be a negative predictor of intention to leave, and participants with a nursing degree reported higher levels of perceived organizational support than those with a diploma. Nurses who felt valued by their institution had better communication with the nursing management and physicians, and consequently were more committed to remaining in their position. Similarly, it has been found that nurses practising in healthy unit work environments within magnet hospitals in the United States are more likely to remain in their current position (Kramer, Maguire, & Brewer, 2011); these nurses are also more likely to have a degree. At a time when retention of experienced RNs is crucial, managers need to consider how to improve the perception of support among diploma-prepared nurses.

Participants who identified their sexual orientation as gay were significantly more satisfied with work factors. One of the participants stated, "When I started in 1989 — everyone assumed you were gay — now — not so much . . . males are much better accepted now than when I graduated." Gay men and lesbians who work in supportive environments with non-discriminatory policies have higher levels of job satisfaction and lower levels of job anxiety (Griffith & Hebl, 2002; Tejeda, 2006). Considering the small sample size, further research is warranted to explore this finding.

Gender Mistreatment and Intention to Leave

A unique finding of our study was the significant predictive relationship between gender mistreatment and males' intention to leave. Nurse managers must be cognizant of the subtle and not so subtle behaviours directed towards male nurses that are perceived as gender mistreatment. Patients are not assigned to female RNs based on their physical attributes, yet males in our study repeatedly referred to inequitable assignment based on the size and/or aggressiveness of the patient. Other studies have found similar results, with males experiencing more aggression in the workforce (Andrews et al., 2012) as well as discrimination (McMurry, 2011) and role strain by virtue of being in a female-dominated profession (Simpson, 2005).

Interestingly, McMurry (2011) refers to the issue of social status, with male RNs looked upon as taking a step down in status whereas females who enter male-dominated professions are viewed as taking a step up in status. Males in our study expressed frustration, as reflected in the following comments: "I am sick of having my gender placed in front of my profession. How often do you hear people say female doctor? I feel 'male nurse' makes me an oddity." "For almost 34 years in the profession I have consistently [felt] that I need to be better than my female peers, and a culture exists that lessens my skills, abilities and experience over that of my female counterparts. Also, patients have questioned my ability mainly on the fact that I am male and not female." Several participants expressed concern that they assumed greater responsibility because of their gender: "Patient assignments are tailored to gender; for example, male RNs get the heavier patients (bariatric) and the more violent patients with greater frequency than the female RNs." Further study is needed to determine how common and widespread preferential treatment or discrimination based on gender is in the RN workplace.

Limitations to this study include the cross-sectional design, surveying only those nurses working in acute-care settings, and the 30% response rate. Previous researchers have found similarly low response rates in mail surveys of professionals. For example, Cobanoglu, Warde, and Moreo (2001) found that mail surveys of professors yielded a response rate of 26%, as compared to 44% for Web surveys. Cho, Johnson, and VanGeest (2013) report low and declining response rates for health professionals and identify challenges involved in surveying clinicians, including competing demands and priorities and practice environments that are not conducive to participating in survey research. Although the sample of 382 male RNs provided adequate statistical power for our analyses, a higher response rate would have allowed for further exploration of diverse characteristics and their impact on satisfaction and intention to leave.

Implications for Practice and Research

A unique finding of our study is the significant predictive relationship between gender mistreatment and males' intention to leave. Raising awareness in nursing practice, research, and education domains of the subtle and not so subtle behaviours directed towards male nurses will lead to an improved work environment for male RNs. Participants repeatedly referred to the inequitable assigning of heavy and violent patients to them. There is a need to further research the higher reported rates of violence experienced by male nurses in clinical practice (Shields & Wilkins, 2009).

Though professional development opportunities are important, regardless of gender (Bjork et al., 2007), Rajacich, Kane, Williston, and Cameron (2013) found that they were a key determinant of male nurses' satisfaction with their current employer. Other researchers have found that participating in research, being able to write up and publish research, and having on-the-job learning opportunities increase nurses' level of job satisfaction (Cortese, 2007). Nursing management needs to understand the impact of union rules on work satisfaction and use creative strategies to integrate professional development, such as journal clubs and participation on quality-improvement teams, into the unit's work environment.

We are conscious of the fact that, by virtue of identifying our participants as "male nurses," we are labelling them as "the other." Perpetuating the practice of treating the male nurse as the other has implications for educators, managers, and researchers. A cultural change is needed both within professions and in society so that professionals are not identified by gender. Within the nursing profession, reflecting on our behaviours and identifying actions that reinforce the feminization of nursing is the first step towards cultural change. The broader, more challenging nature of societal change is evident in the following comments by participants: "Professional and social acceptance is a constant struggle." "The disrespect from physicians & allied staff and the assumption from the administration that you (the nurse) will never complain and can always be pushed further. Being male is not the problem, being a nurse — a caring dedicated professional, no matter what — that's the problem."

In conclusion, if we are to recruit and retain males in the profession, we will have to treat them in a fair and just manner. Recognizing the work factors that influence male nurses' job satisfaction and intention to stay in the profession will ultimately benefit all nurses, as we strive to be responsive to the needs of a diverse workforce within an equally diverse society. We echo the words of one of our participants: "There is a place for men in nursing . . . we offer a balance to the profession and a different perspective to nursing care . . . men will help this profession grow."

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CJNR 2014, Vol. 46 Nº 3, 110–127

Seeking Connectivity in Nurses' Work Environments: Advancing Nurse Empowerment Theory

Sonia Udod

The purpose of this study was to investigate how staff nurses and their managers exercise power in a hospital setting in order to better understand what fosters or constrains staff nurses' empowerment and to extend nurse empowerment theory. Power is integral to empowerment, and attention to the challenges in nurses' work environment and nurse outcomes by administrators, researchers, and policy-makers has created an imperative to advance a theoretical understanding of power in the nurse–manager relationship. A sample of 26 staff nurses on 3 units of a tertiary hospital in western Canada were observed and interviewed about how the manager affected their ability to do their work. Grounded theory methodology was used. The process of seeking connectivity was the basic social process, indicating that the manager plays a critical role in the work environment and nurses need the manager to share power with them in the provision of safe, quality patient care.

Keywords: nurse, nurse manager, empowerment, power, leadership

Résumé

La quête de liens dans les milieux de travail des infirmières et infirmiers : une contribution à la théorie de l'autonomisation du personnel infirmier

Sonia Udod

L'objectif de cette étude était d'examiner comment s'effectue l'exercice du pouvoir par les gestionnaires et le personnel infirmier en milieu hospitalier afin d'une part de mieux comprendre ce qui favorise ou contraint l'autonomisation des infirmières et infirmiers et d'autre part de contribuer au développement de la théorie de l'autonomisation du personnel infirmier. Le pouvoir d'action faisant partie intégrante de la notion d'autonomisation, l'attention portée par les administrateurs, les chercheurs et les décideurs aux résultats du personnel infirmier ainsi qu'aux difficultés avec lesquelles celui-ci doit composer dans son milieu de travail a rendu nécessaire le développement d'une compréhension théorique plus approfondie de l'exercice du pouvoir au sein de la relation qui lie les gestionnaires aux infirmières et infirmiers. Un échantillon composé de 26 membres du personnel infirmier de 3 unités d'un hôpital de soins tertiaires de l'ouest du Canada a été observé et soumis à des entretiens portant sur la façon dont les gestionnaires influencent la capacité des infirmières et infirmiers à effectuer leur travail. Une méthodologie favorisant le développement d'une théorie enracinée dans les données empiriques a été employée. L'étude a permis de constater que la quête de liens est le processus social fondamental à l'œuvre, ce qui indique que les gestionnaires jouent un rôle essentiel dans le milieu de travail et que le personnel infirmier a besoin que ceux-ci partagent avec lui l'exercice du pouvoir pour assurer la prestation aux patients de soins sécuritaires et de qualité.

Mots-clés : infirmières et infirmiers, gestionnaires du personnel infirmier, autonomisation, pouvoir, exercice du pouvoir

Introduction

The central idea of empowerment theory is the power that individuals need in order to do their work in a meaningful manner (Kanter, 1977, 1993). A key responsibility of nurse leaders is to create conditions that empower nurses to provide the best possible care in a healthy work environment that fosters professional practices and effective working relationships (Laschinger, Finegan, & Wilk, 2009; Laschinger, Gilbert, Smith, & Leslie, 2010). The increased attention to the challenges in nurses' work environments and nurse outcomes has created an imperative to investigate nurse empowerment in greater depth and breadth (Udod, 2011).

Background

Power, according to Kanter's (1977, 1993) theory of structural power, is associated with the ability to mobilize resources to get things done. Accordingly, work environments that provide access to resources, support, and information empower nurses to do their work in meaningful ways (Kanter, 1977, 1993). From this perspective, power is associated with granting power and is shared for everyone's benefit. Kanter argues that managers play a key role in assuring nurses access to sources of empowerment in work settings, a position that is confirmed by Laschinger's research (Greco, Laschinger, & Wong, 2006; Laschinger, 1996; Laschinger, Wong, McMahon, & Kaufman, 1999). Empowerment is a tool used to motivate nurses and is manifested by a degree of clinical judgement within one's scope of practice in caring for patients to achieve organizational goals. Access to empowering structures is heightened by specific job characteristics and interpersonal relationships that foster communication through formal and informal power. Relationships have been found between empowerment and decreased levels of job stress and emotional exhaustion/burnout (Kluska, Laschinger, & Kerr, 2004; Laschinger, Finegan, & Shamian, 2001; Laschinger, Finegan, Shamian, & Wilk, 2003).

In contrast, Conger and Kanungo (1988) and Spreitzer (1995) highlight the key role of leadership behaviour in shaping nurses' work experiences. The motivational approach to empowerment involves sharing power and information to increase nurses' confidence in their own effectiveness and thus improve productivity. By enabling nurses to develop a sense of ownership in their work and the organization, empowerment is thought to increase nurses' commitment and involvement, ability to cope with adversity, and willingness to function independently (Conger & Kanungo, 1988; Thomas & Velthouse, 1990). Spreitzer (1995) developed a scale to measure four cognitive domains: *meaning* (the fit between a given activity and one's belief, attitudes, and behaviours); *competence* (belief in one's ability to perform a task); *impact* (belief that one can influence organizational outcomes); and *self-determination* (sense of control over how one performs one's job).

Nurse researchers have found that involvement in unit decisions, supportive management, trust in management, and job satisfaction have been positively linked to staff empowerment (Laschinger & Finegan, 2005; Laschinger, Finegan, Shamian, & Wilk, 2001; Laschinger & Havens, 1996). From a psychosocial perspective, employees who are psychologically empowered value a manager who creates conditions for enhancing their motivation by removing disempowering organizational structures.

Critical social perspectives deconstruct the way that power is embedded in nursing practice (Forbes et al., 1999). Since the early 1990s there has been increasing interest in using critical approaches to inform nursing research (Ceci, 2003; Cheek, 1999; Cheek & Gibson, 1996; Cheek & Porter, 1997; Fahy, 2002; Fulton, 1997; Manias & Street, 2000). These approaches challenge the status quo, highlight marginal voices in dominant discourses, and explore issues of power and knowledge in nursing. For nursing, critical social theory offers a research perspective that may help "uncover the nature of enabling and/or restrictive practices, and thereby create space for potential change and, ultimately, a better quality of care for patients" (Wells, 1995, p. 52). Collectively, the results of these studies suggest that, in conjunction with staff nurses' tenuous relationships with their supervisors (Laschinger & Finegan, 2005), building trust between nurses and their managers is critical to patterns of nurse empowerment within relations of power that contribute to a positive work environment (Hardy & Leiba-O'Sullivan, 1998; Laschinger & Finegan, 2005; Moye & Henkin, 2006).

The purpose of this study was to extend empowerment theory to explain how staff nurses and their managers exercise power in a hospital setting, and thus to better understand what fosters or constrains staff nurses' empowerment. The study was guided by two questions: 1. *How are staff nurses and their managers situated in social relations of power?* 2. *What is the context in which these interactions occur?*

Research Method

A grounded theory method (Strauss & Corbin, 1998) was used to theorize the process of how nurses and their managers exercise power in their relationships. It was anticipated that this inquiry would provide the foundation for "the elaboration of existing theory" (Suddaby, 2006, p. 635) to produce a better understanding of how nurses exercise power, thus influencing empowerment practices.

Sample

The sample comprised registered nurses chosen on the basis of their experiences with the social process under investigation (Corbin & Strauss, 2008; Strauss & Corbin, 1998). As the study got underway, theoretical sampling involved gathering data driven by concepts derived from an emerging theory and then determining what people, events, or places would maximize opportunities to discover variation among concepts (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Strauss & Corbin, 1998).

Twenty-six registered nurses were recruited from three units in a tertiary hospital in western Canada. They ranged in age from 20 to over 50, with 40% being between 26 and 30. The majority of nurses were female (88%) and the majority (64%) had a nursing degree or a nursing degree in progress. The length of time the nurses had worked on their current units ranged from 7 months to 24.5 years, with a mean of 7.5 years. The total number of years as an RN ranged from less than 1 to 30, with a mean of 10. One nurse transferred to another unit after her observation and despite repeated attempts the researcher was unable to contact her for a follow-up interview. Nurse managers were not part of the study.

Data Collection and Analysis

In this grounded theory study, data were collected during 2008–09 and are "grounded" in the interactions nurses had with their manager (Chenitz & Swanson, 1986; Creswell, 1998; Morse & Field, 1995). Grounded theorists have the tools to examine and analyze contradictions by focusing on words and actions that may reveal crucial priorities that are key to improving practice (Charmaz, 2005; Corbin & Strauss, 2008). Grounded theory's potential for developing theory remains untapped, as does its potential for studying power (Charmaz, 2005). It is the method of choice for investigating the exercise of power between nurses and their managers.

Power was explored in the hospital as the context in which staff nurses work and observational fieldwork helped capture how power was exercised. The researcher observed staff nurses on all three shifts (days, evenings, and nights) over a period of 3 to 4 hours at various times of day and on different days of the week. The goal during these observations was to pay close attention to the design of the unit, the social relationships in the work environment, and the practices that shaped nurses conduct in terms of how staff nurses and their manager exercised power. The ways of thinking and behaviours that were produced surrounding nurses' ability to do their work illustrated the workings of power. The researcher attended to the purpose and frequency of staff nurses' informal discussions with managers, the extent to which staff nurses participated in decision-making affecting their professional practice, and management behaviours and practices that affirmed or negated staff nurse involvement. The researcher spent 11 mornings, 9 afternoons, and 6 evenings/nights on the units, for a total of 26 episodes of fieldwork. In total, 90 hours were spent in the field making observations. Spradley's (1980) framework was used for documenting field notes containing the researcher's impressions, insights, and interpretations of what was observed in the field and served as an analysis of social relations of power integral to staff nurse empowerment.

Semi-structured interviews lasting from 40 to 60 minutes were conducted with the participants in a quiet room in the hospital or in the researcher's office connected to the hospital. An interview guide consisting of questions gleaned from the literature on organizational empowerment became more focused as a result of participant observations.

The study received ethical approval by the university and the regional health authority.

In keeping with the guidelines for grounded theory, data collection and analysis were conducted concurrently using constant comparative techniques (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Opie (1992) suggests that focusing on the differences in observing and interviewing participants is comparable to Glaser and Strauss's (1967) constant comparative method. Therefore, in open coding, interview transcripts and observations were analyzed line by line and generated several categories, such as *working without an anchor* and *stepping up of power,* and descriptive codes were written in the margins. By keeping codes active, the researcher was able to preserve the process and differentiate later sequences following multiple observations and interviews. In the second level of coding, categories were related to subcategories along the lines of properties and dimensions to form more precise and comprehensive explanations of phenomena (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Finally, the core category that emerged was *seeking connectivity,* and it was systematically related to other categories until a pattern of relationships was conceptualized (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Data saturation was achieved when there were no significant additions to the data and the theory "made sense" (Morse & Field, 1995).

Findings

Seeking connectivity was the basic social process in which nurses strived to connect with their manager to build a workable partnership in the provision of good patient care while responding to organizational demands. Conditions, actions, and consequences formed the theory of seeking connectivity as an extension of nurse empowerment theory. First, five contextual factors represented the conditions in the organization that influenced nurses' relationships with their manager. Second, five themes related to how nurses and their managers exercised power in their relationships: (a) *working without an anchor,* (b) *silencing forms of communication,* (c) *stepping up of power,* (d) *positioning to resist,* and (e) *experiencing the potentiality of enabling*. The last two of these — (d) and (e) — concern nurse responses to the relationship of power. Through encounters with contextual factors (conditions), and as a result of nurse–manager actions and interactions, nurses responded to and shaped the situations in which they found themselves in order to provide patient care in satisfying ways.

Organizational Context

Five key contextual factors in the hospital influenced nurses' relationships with their manager. First, the budget was incorporated into nurses' everyday language; their care had become a cost-conscious activity driven by economic efficiency and resource constraints. Second, "working short" was defined as a lack of nursing personnel; sick days were not filled for budgetary reasons, which influenced how nurses managed their workloads. When nurses experienced a shortage of professional nursing staff, their work activities became less controllable. Third, all nurses expressed concern about the frequency with which they were being "pulled away" by competing organizational priorities; they had to temporarily stop direct patient activities and respond immediately to overcapacity alerts, provide documentation, and dispense medications at the designated time, while also responding to myriad non-nursing duties. Fourth, the nature of policies was an organizing and dominant feature of nurses' work. Institutional policy decisions re-organized nurses' judgement and actions in line with managerial priorities, and occasionally affected nurses' ability to provide good care because they had to juggle patient care with meeting organizational demands. Finally, organizational priorities increased the scope of nurses' workloads, and they perceived that their actions could jeopardize patient safety and their professional licences.

Nurse and Nurse Manager Relations

Working without an anchor. In this category, nurses described engaging in their work without the consistent support of their manager. However, the extent to which this occurred varied with each nurse. Nurses characterized the manager as subordinating nursing and patient care practices to organizational priorities.

The manager's lack of visibility and nurses' inability to interact with the manager in a regular and consistent manner exacerbated their perception of working in isolation. The lack of visibility adversely affected their access to knowledge and engagement in decision-making, and they believed that this limited the manager's understanding of patient needs and time constraints. Nurses perceived the manager's lack of awareness of what was happening on the unit as a dissonance between the needs of patients and the manageability of nurses' work:

> *There's a lot of questions. If you did ask for a sitter to come . . . she'd really grill you about why are you doing this: "Is this really appropriate?" She was looking at the dollar figure more than how stressed we were at work or what our work environment was . . . it really puts a lot of stress on you to hear that.*

In the views of the nurses, managers had limited clinical knowledge and experience, which constrained their ability to understand the complexities of nurses' work and to advocate in the best interests of nurses and patients:

> *She [the manager] needs to be involved in [the] day-to-day . . . she goes to meetings, [is] not really on the ward; she doesn't have a very broad knowledge base [in] nursing.*

> *She was . . . almost never accessible to anyone on the floor, for any reason, whether it was to do with staffing issues, workload issues, with the basic needs . . . it seemed like there was always something more pressing.*

In general, working without an anchor accentuated the tension that nurses experienced in meeting organizational demands while providing patient care, without the consistent and active engagement of the manager in facilitating and guiding professional responsibilities.

Silencing forms of communication. Silencing forms of communication refers to how communication patterns were circumscribed between managers and nurses, reinforcing the isolation that nurses experienced. Nurses perceived themselves as "having to go along" with the manager and/or management's policy changes without dialogue to elicit their viewpoints. Nurses described input into policy changes regarding staffing levels, the patient delivery model, and documentation as either circumscribed or non-existent. The manner in which the policies were communicated by the manager gave the impression of a non-negotiable edict, according to one nurse: "She says we'll use it as a guideline, but everything seems to be kind of set in stone." Another nurse described the lack of input into the changes to the patient care delivery model: "It kind of came out of left field and just kind of landed and we were told to scurry away and do it."

Rather than assuming a leadership role in executing a change process by preparing and meeting with staff, one manager let the educator assume the role of "pushing" the policies:

> *From what I see, [manager] has a very silent role . . . through this whole thing I've never actually heard her discuss any of the changes with any of the staff. If you approach her she'll explain the reasoning, but she's not one to hold staff meetings.*

In general, promoting one-way communication with minimal ability to exchange ideas may have been a way for managers to minimize conflict and retain power while responding to organizational mandates over which they had little control. It may have been a way for them to handle a polarized situation as each struggled for control over how contextual factors would influence nurses' work.

Stepping up of power. This was categorized by the nurses as the manager's supportive attitudes, guidance, and behaviours in enhancing nurses' control over their work despite the contextual demands of the workplace. The manager acted as a liaison to support nurses and/or resolve conflict between nurses and patients, families, or other health professionals, especially when there was a power differential. One nurse described the manager as someone who could advocate for and support nurses in ways that facilitated their patient care activities:

> *Often on this unit we've had troubles with the physicians . . . you kind of need someone at a higher source of power because there's too much of a power space between the nurses and physicians.*

Nurses suggested that when the manager engaged with nurses, solicited feedback, and was receptive to their opinions and professional judgement on decisions affecting their work, nurses responded favourably:

> *When she [nurse manager] started I was really impressed that she came around every day and introduced herself. She grabbed you for maybe 15 minutes and would ask what you would do to improve the place — she really wanted to know what was going on.*

In general, stepping up of power was characterized by the manager's accessibility on the unit, seeking a close-up view of the demands of nurses' work and redirecting her activities to actively support nurses in their provision of patient care. This raised nurses' comfort level in interacting with the manager and contributed to nurses' trust in their manager.

Nurse Responses

Positioning to resist. Nurses' resistance strategies were intermittent and were deployed at multiple points along a continuum to challenge the power imbalances between themselves and their managers. Nurses did not take an "all or nothing" approach to resistance towards their managers and role responsibilities. A close reading of the data suggests that there were deep-rooted resistances at play that were not always apparent or easily discernible. Yet at other times the resistance demonstrated by nurses was overt and readily apparent.

An aspect of positioning to resist was characterized as the means by which nurses allowed their manager a trial period to ascertain her fitness for the role of manager. Nurses dropped hints about a manager's trial period, but it was never clear exactly what she needed to demonstrate and when the learning curve expired:

> *[Manager] is still new so we're still giving her a year or two grace, kind of thing. We sometimes wish she would give the ward a whirl to see what it's like.*

Nurses used subtle and not so subtle strategies to get the manager to conform to how they perceived a manager should function. In informal meetings with one manager, nurses used a variety of suggestions to persuade the manager to change her behaviour:

> *I think there was maybe a handful of senior staff who'd had 20-plus years' experience [and] just felt they had a lot to teach her. I said, "If you had come to report, you'd kind of know what the floor looks like — if we're over-census, who we can take and who our pre-books are."*

Nurses demonstrated more overt forms of resistance when workloads became unmanageable. This was particularly evident in the actions related to policies, such as not consistently adhering to the new patient care delivery model and not documenting immediately. Doing the bare minimum was one way nurses coped with "doing more with less":

> *You need to sometimes just step away for a few minutes . . . patients not getting washed; you kind of have to weigh . . . what's the most important and prioritize things, so maybe someone will not get washed up before they go home.*

Occasionally, nurses engaged in unproductive acts of resistance, yet the most successful acts of resistance were the result of their collective decision to act as patient advocates. A more detailed analysis of resistance related to the exercise of power between nurses and their manager will be outlined in a future publication.

Experiencing the potentiality of enabling. Nurses experienced the potentiality of enabling as advocating for good-quality patient care when the manager was supportive of nurses in their practice environments. When the manager minimized the demands of the organization, this enabled nurses to believe in the manager's reliability and dependability and increased nurses' sense of control over their work. Nurses were then able to provide the quality of care they believed necessary to promote and enhance patients' health and well-being, thus making a difference to the trajectory of the patient's recovery.

Nurses described the paralyzing fears that patients faced as they underwent advanced medical therapies or life-threatening surgeries: "You go in there and hang the chemotherapy and they're like deer caught in the headlights and they're absolutely frightened." Nurses described patients as being attentive and as having confidence that the nurse was making a difference to their recovery and well-being:

> *I've always done my medicine [nursing care] in totality. I'm able to talk [to patients]. I've had some patients tell me [that] because they had time to talk with me they felt better even though they had been feeling down.*

Nurses believed they were able to focus on direct patient care when the manager intervened to regulate organizational processes and practices. Nurses were then able to use their knowledge and expertise to engage with the patient for the purpose of promoting good health behaviours and health outcomes.

Discussion

The basic social process that emerged was *seeking connectivity,* defined as nurses' striving to connect with their manager to build a workable partnership for the provision of quality care while responding to organizational demands. This theorization is an extension of empowerment theory and explains how nurses and their managers exercised power in their relationships and how seeking connectivity either hindered or fostered their ability to feel empowered in the work setting. The overarching finding is that the manager plays a critical role in modifying the work environment for nurses and therefore nurses seek connection with their manager.

In an organizational context, budgetary priorities, policies, and efficiency-oriented interruptions combined in various ways to influence nurses' thinking and shape their actions. The hospital sought to maintain power through a series of mechanisms affecting the way that nurses' work was structured and circumscribed to align with centrally determined policies and practices that downplayed nurses' professional judgement about patient care. According to the critical social perspective, nurses' work is situated in institutional structures where policies represent a sophisticated form of power over nurses and their work (Rankin & Campbell, 2006). Other studies report similar findings in that hospitals are providing an increased intensity of care with fewer nurses striving to meet patient needs (O'Brien-Pallas et al., 2005; Priest, 2006). Cost containment and efficiencies have served to limit the range of services; when hospitals wish to save money they cut back on nursing personnel, creating a stressful work environment and potentially compromising the quality of care (O'Brien-Pallas et al., 2005; Priest, 2006; Rankin & Campbell, 2006). The present study reveals, from a structural perspective, that reasonable workloads and time (Kanter, 1993) are essential for nurse empowerment.

The first theme, *working without an anchor,* is congruent with the findings of other nursing studies. New governance models have found that nurse managers have increased spans of control (Laschinger et al., 2008; McCutcheon, Doran, Evans, McGillis Hall, & Pringle, 2009) and decreased visibility and availability for mentoring and support (Canadian Nursing Advisory Committee, 2002). However, the literature on magnet hospitals confirms that a supportive manager is one who is available, responsive, and approachable (Kramer et al., 2007). From a motivational empowerment perspective, Laschinger and Finegan (2005) note the importance placed on autonomy by professional nurses, yet nurses in the present study reported deficits in autonomy. Rankin and Campbell (2006) report that nurse leaders learn to apply text-based methods of managing nurses, which include assessing workload and ensuring documentation standards in response to their lack of accessibility on the unit. Without the active engagement of the manager, nurses experience the added pressure of having to address organizational priorities while also providing patient care. Without the manager's availability to navigate complex institutional bureaucracies, nurses lack a sense of involvement in their work (Conger & Kanungo, 1988; Thomas & Velthouse, 1990).

The second theme, *silencing forms of communication,* is congruent with the findings of other studies describing nurses' limited ability to negotiate or contribute to decisions affecting their practice. Daiski (2004) found that nurse disempowerment resulted from nursing leadership aligning with hospital administrators, nurses receiving little respect from managers, and nurses being excluded from decision-making processes. Other researchers suggest that nurses' exclusion from decisions that affect their work results from a failure to acknowledge nurses' professional judgement based on their close contact with and observation of patients (Cheek & Rudge, 1994; Peter, Lunardi, & Macfarlane, 2004). Critical social empowerment demands that nurses have an equal voice in decision-making and collaborate with their manager in recognition of their potential contributions to the organization (Casey, Saunders, & O'Hara, 2010). In the present study, nurses found value and power in the nurse–patient relationship but did not always believe that their knowledge and expertise were being recognized.

The third theme, *stepping up of power,* is interpreted as supportive leadership behaviour: being accessible to communicate and exchange information, exhibiting a positive management style, providing feedback, and offering expressions of caring (Corbally, Scott, Matthews, Gabhann, & Murphy, 2007; Faulkner & Laschinger, 2008; Kuokkanen & Leoni-Kilpi, 2001). These findings align with those of Laschinger and Shamian (1994) suggesting that when managers have access to information, resources, and support they are able to influence nurses' access to similar empowerment structures. In the present study, as with Spreitzer's (1995) concept of psychological empowerment, stepping up of power characterized nurses as able to practise autonomously and exercise control over their work despite the demands of the organizational environment.

The fourth theme, *positioning to resist,* is congruent with the findings of an ethnographic study by Street (1992) suggesting that nurses are most articulate when speaking about their relationship with the nursing administration. Studies report that "speaking up" is an act of resistance and that nurses speak up in response to moral distress and ethical concerns (Peter et al., 2004; Sundin-Huard & Fahy, 1999; Wurzbach, 1999). Indirect forms of resistance are those in which nurses' actions are aimed at stalling or pretending not to notice events in order to advocate for the patient (Hutchinson, 1990). Nurses' most assertive acts of resistance rely on their professional knowledge of patient care and include providing documentation and going to a higher authority (Peter et al., 2004; Schroeter, 1999). Consistent with a critical social perspective, where the redistribution of power often involves conflict and resistance to the dominant nature of bureaucratic processes and structures, the present study adds to these findings, as nurses manipulated their practice as a way to exercise power and control over their work.

The final theme, *experiencing the potentiality of enabling,* illustrates how nurses feel more empowered when their manager promotes professional behaviours and supportive relationships, which ultimately has an impact on safety, the quality of care, and the quality of the work environment (Boyle & Kochinda, 2004; Laschinger, Finegan, Shamian, & Wilk, 2004; Ulrich, Buerhaus, Donelan, & Dittus, 2005). The present findings demonstrate that structurally empowered work environments are the outcome of leadership practices that foster employee feelings of respect and organizational trust (Laschinger & Finegan, 2005; Laschinger et al., 2004). Similar to Spreitzer's (1995) construct of competence, experiencing the potentiality of enabling was characterized as nurses' ability to practise according to professional standards.

Limitations

Although the sample size was limited, the intention of this qualitative study was not to generalize the findings but to extend the theory (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Including both nurses and their managers in the study might have resulted in a more balanced perspective, especially in light of the high turnover of managers encountered on one of the units. There was a sense that some participants wanted "to get back at" their manager. Fendt and Sachs (2008) argue that the "first requirement of qualitative research is faithfulness to the phenomena under study" (p. 450). In response, the researcher demonstrated sensitivity to the phenomena and sought to capture the essence of participants' narratives (Corbin & Strauss, 2008).

Conclusion

The findings reveal that the manager plays a critical role in modifying the work environment. The findings highlight the way in which power is mobilized by nurses and managers in the context of structural empowerment, psychosocial empowerment, and critical social empowerment, and they clarify how the theory of seeking connectivity advances nurse empowerment theory. Okhuysen and Bonardi (2011) argue that management issues often require explanations developed from a combination of perspectives to provide answers to complex questions. Most revealing is that the critical perspective of empowerment discloses power relations that perpetuate hierarchical structures in nursing practice and the ways that these power relations affect the daily lives of clinical nurses. In a future publication the author will analyze how nurses' resistance can introduce alternative discourses to dominant organizational and managerial discourses through critical social empowerment.

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Acknowledgements

The author gratefully acknowledges the assistance and support of Dr. Diane Doran at the Lawrence S. Bloomberg Faculty of Nursing, University of Toronto, in facilitating this doctoral study. Sincere thanks are also extended to Drs. Jan Angus and Heather Laschinger for their intellectual contributions. The author gratefully acknowledges the participation of the Saskatoon Health Region in the study.

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