

EDITORIAL

The Values of the Nursing Discipline: Where Are They in Practice?

Recently I was invited to give a talk on integrative oncology to university nursing students — some were generic students, others post-RNs returning for a BScN degree. One of the goals of the presentation was to highlight three concepts that lie at the core of integrative oncology and that also happen to be coveted values of the nursing discipline: *healing*, *health*, and *caring for the whole patient* (Skretkovicz, 2010). When patients suffer due to a life-threatening or chronic illness, their psychological distress is experienced throughout the whole being, from the molecular domain to the spiritual. Yet how that emotional distress affects the biological as well as the behavioural health and healing processes of the whole person remains to be clarified.

Although nursing and medicine share a general bio-psycho-social model as the basis for generating scientific knowledge about the human being, biological findings in particular have been filtered through a reductionist perspective, making it all but impossible to operationalize health and healing, in the context of an integrated whole person. But what if the biological and behavioural health of the person were to be examined from a slightly different perspective, one in which the whole being is understood in the context of resilience, a key property of health and healing? Resilience has been shown to be regulated by the neuro-endocrinal and immune systems within a ubiquitous informational network of stress and other mediators that ensure cohesive and coherent functioning throughout the whole person.

Why is this conceptualization of the whole so important? Although nurses are knowledgeable about the patho-physiology and treatment of disease, the relationship between health (resilience) and illness has not been well elucidated biologically. Perhaps for that reason, nurses have tended to focus care on the illness and symptoms, overlooking the benefits of also promoting the patient's health. Yet research findings have shown that resilience and disease are inversely and intimately linked (McEwen, 2007).

Scientific knowledge about the toxic effects of stress on neuro-endocrinal and immune structures, processes, and functions would help us identify the affected biological as well as behavioural targets and pathways that must be strengthened and or mobilized in order to support

medical treatment and/or help the patient live well with the illness. These biological indicators would be used to assess clinical interventions designed to mobilize healing and strengthen resilience. Using both biological and behavioural indicators provides a more reliable measure of the overall adaptive capabilities of the patient and the multi-targeted effectiveness of our interventions. Finally, the nurse's scientific knowledge about the biological mechanisms of resilience, of which healing is an integral part, would provide an evidentiary-based rationale for promoting a person's health with or without the presence of illness.

Bringing the biology/behaviour of resilience into nursing practice would be a game changer — but in accordance with the values of the nursing discipline. There is growing evidence that when health- and healing-related processes are promoted before, during, and/or after medical treatment, the person's capacity to fight the illness or live well with it can increase. In this paradigm, nurses and physicians truly fulfil a complementary function in enhancing the well-being of the whole patient.

To return to my anecdote, the nursing students in the audience seemed to be aware of this neuro-endocrinal and immune regulator of the stress and adaptation response, having taken relevant courses in the neuro-biological sciences. But several also vocalized the collective dismay of the many students who had tried to introduce new ideas and relevant research findings in their clinical rotations, only to be rebuffed, met with indifference, or dismissed, in keeping with the literature on the socialization of new graduates in the workplace (Feng & Tsai, 2012). Some students shared a belief that scientific knowledge was often “dumbed down” in their clinical settings. Standard procedures seemed to be more valued than cognitive-behavioural approaches. One student, by way of illustration, recounted how a master's-prepared nurse had been reproached by the head nurse for choosing to stay with a distressed patient after work — criticized for his apparent lack of organizational abilities and told that he should not expect overtime! The clear message, intentional or not, was that being fully present for the patient and providing emotional support were not the priority.

This is particularly disappointing to someone like me, who over many decades has had the privilege of occupying a number of leadership positions and has always assumed that the head nurse is the vanguard of and advocate for the nursing profession. Is it not the role of the head nurse to articulate, explain, guide, and ensure that nursing practice is carried out to the full, evidenced-based intent of the discipline? If so, an emphasis on skill formation would surely include competency in cognitive-behavioural strategies as well as procedures and techniques, all of which would be

situated and indeed scientifically rationalized in the context of a nursing framework.

Imagine, if you will, the clinical possibilities had the head nurse been aware of the toxic effects of emotional stress on the whole person, and specifically the biological damage inflicted on neural cellular structures, neuro-endocrinal and immune pathways and functions. Would she have responded differently? Imagine that the head nurse had possessed the scientific knowledge that emotional distress is not only a significant promoter of chronic inflammation but a suppressor of normal immune-protective defences against viruses, bacteria, and even the proliferation of many forms of cancer, while also disrupting biorhythms vital for healing and contributing to cognitive and emotional difficulties. Being cognizant of these scientific findings, she might have addressed her staff nurse differently, and even made the defensible argument for actively changing nursing practice to a whole person model in which not only procedural competence but also the use of evidenced-based cognitive-behavioural skills and other stress-reducing mind-body techniques would be a clinical imperative.

As suggested so beautifully in this issue's Discourse on needless suffering, nursing students need to be mentored by both university professors and clinical nurse experts with a shared knowledge of the scope and science of practice, so that they will graduate with greater clinical competence while reflecting more credibly the goals and values of the discipline. For example, learning would undoubtedly be strengthened by daily clinical rounds led by a clinical expert with in-depth scientific and clinical knowledge about each patient based on a whole person perspective. Clinical rounds would expose students to a wider array of patient concerns and clinical factors to consider, drawing on relevant empirical findings in order to provide optimal care to patients and their families. Through these daily rounds, the clinical expert's expectations of the students would not only help to integrate the science with the art of nursing in the clinical field but also serve as an indispensable role model for clinical nursing practice.

Barriers to Change

We should not underestimate the formidability of hospital barriers to promoting a whole person approach. The clinical emphasis on tasks and procedures is consistent with the values of the medical paradigm, which, unfortunately for patients and families, fails to accommodate the growing body of research underscoring the potential scientific benefits to patients of promoting their resilience (McEwen, 2007). From a sociological perspective, the favouring of procedures over cognitive-oriented care in

medicine, as in nursing, has been likened to what Link and Phelan (2001) describe as a system-wide “structural stigma” in which psychosocial and cognitive-oriented care is the least valued (Link & Phelan, 2001; Unger, 2015).

Nursing supports this institutional favouring of procedures by describing advanced practice nurses in terms of their coordinating functions (nurse navigators) rather than their scientific knowledge and clinical skills in providing expert care to patients and families and in mentoring nursing staff. Nursing also supports this institutional favouring of procedures in those hospitals that still maintain a hierarchical nursing administrative structure, which tends to defuse innovative ideas that might disrupt the status quo. Given this line of thinking, one can understand the frustration of new nursing graduates wishing to try the latest evidenced-based clinical approach or to work on more flexible decentralized nursing units. As professionals, nurses should have the option, indeed the right, to determine among themselves how their work will be organized, which conferences they will attend, and which invitations to lecture they will accept. As professionals, nurses need to be more accountable for their practice and to be free of seemingly patronizing clinical structures and processes that limit professional actualization.

The Future of Nursing

Happily, the winds of change are blowing across Canada. Planning for a new, countrywide, university-based nursing curriculum to meet the health-care imperatives of the 21st century will be a challenge. Among the myriad issues to take into account are a rapidly changing health-care system responsive to scientific discoveries regarding the genome and the patho-physiology of disease, both longstanding and emerging; the latest technological advances; new treatments in a world faced with increasing resistance to antibiotics; the rise in mental health problems; and an aging population often afflicted with more than one chronic illness. But of equal import is the growing body of scientific evidence indicating that many chronic illnesses, including rheumatoid arthritis, diabetes, some cancers, depression, anxiety, and post-traumatic stress disorder, are a function of prolonged psychosocial stress that undermines resilience capabilities and health across the lifespan.

Against this critical backdrop, the 2014 National Nursing Education Summit was convened to establish academic guidelines in accordance with the anticipated health-care needs in the 21st century. Four general domains to guide the development of a national education strategy for nursing were identified. Of the four, two domains seem particularly relevant to the topic of this editorial.

The first domain is the need, Canada-wide, to strengthen nurses' foundational knowledge. A proactive initiative of committed university-based and clinically based scholars and clinical experts to lay out the goals, values, foundational concepts, and desired outcomes of the discipline based on an integrated health and healing perspective of the whole person would finally, I believe, help to elucidate the three core values of the discipline in educational, clinical, and research spheres of practice.

Many university nursing programs enjoy close professional ties with their clinical affiliates. Yet the countrywide initiative described above will offer a real opportunity to delineate a foundational scope of practice that is shared across university and clinical settings, coast-to-coast, enabling all nurses to speak the same language of practice, perhaps for the first time. This groundswell of professional unity could also provide the impetus for us to create scientifically defensible conditions for practice. This shared understanding of what nursing is would go a long way towards addressing the disconnect between what nursing professes to value and what generally happens in the clinical world.

The second proposed domain of the National Nursing Education Summit that I wish to address is the need to develop leaders and change agents. Although developing change agents and nursing leaders has always been a part of curricula, I sense that the approach to this formidable challenge will be substantially different. If it is not, I submit, too much responsibility will continue to be placed on the new graduate, with predictable results. As we all have witnessed over the years, teaching our students to be change agents takes them only so far unless there is tangible support from the top nursing administrative echelons of a hospital. Conversely, our mission, as faculty, to form articulate, knowledgeable professionals capable of standing up to inequity and finding solutions to advance the profession has been confounded at times by the mixed messages that we send about "rocking the boat" (Day & Benner, 2015). As I reflect back on my own career, the changes in nursing's clinical practice that I happened to be part of were possible, ultimately, only because of the unwavering support of the medical director. The nursing directorate would step back, powerless against the intense emotional reactivity of many physicians to any shift towards a more comprehensive nursing practice — benefits to their own patients and families notwithstanding.

As the future of health care lies before us, it is becoming increasingly evident that nursing and medicine must share a greater depth of scientific knowledge about the human being at multiple levels, from the molecular to the behavioural and the spiritual in the context of the internal/external environment. At the same time, each profession must bring its unique perspective and empirical knowledge to the clinical care and treatment of patients and families.

But huge institutional inequities, with all their embedded biases, must also be confronted and addressed, in a manner that not only ensures patient safety — is that not a given? — but also recognizes the right of nurses to practise to the full extent and scope of their profession. Considering that nursing is one of the key health professions, should that not also be a given? We need to address these issues head on, in the realization that changing a university curriculum must take place in the context of clinical practice, and vice versa. Both university curricula and clinical practice must be predicated on shared scientific knowledge as well as the goals and values of the discipline, if we are to even hope for a fundamental change in how patients and families are cared for by university-prepared nurses.

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