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Re-valuing nursing's currency: Shifting away from hierarchical binary opposition

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SUMMARY

This paper starts a discussion amongst nurse educators internationally regarding the nature of curricula for initial nursing licensure. Nursing is compelled by traditional views of nursing into taking a long-established and expected place in the health care hierarchy, which is reflected in current curricula. In order to establish a re-valued nursing currency within healthcare, nursing educators are required to re-examine these established norms and re-design these curricula, based on the premise that nursing is now set in a complex and unpredictable system.

Introduction

This paper aims to instigate a discussion amongst nurse educators internationally regarding the nature of curricula for initial nursing licensure.

It is the contention of the authors that nursing is compelled by traditional views of nursing into taking a long-established and expected place in the health care hierarchy, which is reflected in current curricula. In order to establish a re-valued nursing currency within healthcare, nursing educators are required to re-examine these established norms and re-design these curricula, based on the premise that nursing is now set in a complex and unpredictable system.

Binary Opposition in Nursing

Nursing is in a state of flux. As in many parts of the world, nursing in the United States and the United Kingdom has been required to change and adapt in response to economic and political policy drivers that impact our health care systems. The implementation of policy within these countries has relied upon the effective implementation of the outcome and conclusion of national health agency reports which emphasize the uptake by nurses of roles and skills which have been, hitherto, within the domain and responsibility of medical colleagues (Wilensky, 1964; IOM, 2010). In response to this, the preceding three decades have witnessed a well recorded change in both the organization and practice of nursing in many areas (Royal College of Nursing, 2012; Christian et al., 2007). These changes are projected to intensify as Accountable Care Organizations crystallize in the United States and the organizational effects of the Integration of Health and Social Care agenda take form in the United Kingdom (Centre for Medicare and Medicaid Services, 2013; Department of Health, United Kingdom, 2013).

Although nursing has endeavored to change in many respects over the past three decades and much evidence to suggest that nurses provide at least as good service as their medical colleagues (Laurant et al., 2005); nursing continues to strive to gain recognition and identity as a partner profession to medicine and to increase the value of the currency of nursing per se by both medical colleagues and the community which nursing serves (Phillips et al., 2000; Donelan et al., 2013; IOM, 2010). It is the opinion of the authors that these transformations in nursing have often left nursing polarized between what it has been and the uncertainty of what it is attempting to move towards. It is, on one hand, drawn by traditional concepts, relationships, and notions of nursing practice; and, on the other, by calls to change and re-think the role and position of nursing.

Binary opposition is a concept which juxtaposes two contrasting terms where the language employed is often used to explain and describe the values that society places on specific words, for example married/single or beautiful/ugly. Derrida (1974) further developed this concept to suggest that, in addition, one of these terms is usually given a positive value and the other, a negative value — in other words one has a power over the other with one concept seen as desirable, the other unwanted. Therefore, it is necessary to understand one position in relation to the other and in relation to the context in which they are set: the terms are symbiotic and not mutually exclusive.

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According to Derrida (1974, p. 65) "it is not enough simply to neutralize the binary oppositions of metaphysics. We must recognize that, within the familiar philosophical oppositions, there is always a violent hierarchy. One of the two terms controls the other (e.g., axiologically, logically), and holds the superior position".

In this paper we suggest that the binary terms are the traditional role versus the contemporary ways of nursing. Further, that the superior position of long standing is that of the traditionally defined role of nursing as outlined by Nightingale (Bohnam-Carter, 1867). Today in nursing care delivery, the work of the nurse has similarities to the traditional role of nursing, yet nurses and nursing care have evolved over the past century and a half. Currently, there seems to be a non-hierarchical binary relationship between the traditional role of the nurse and the emergent patterns of nursing that respond to the health needs of our communities. For the present, nurse educators are grounded in the traditional curriculum while trying to respond to political, social and economic realities of our age that embody the context of health care transformation and reform. At the edge of an often chaotic environment nurse educators and nurses must work and prepare for the changes thrust upon them by society's need for a new type of health care. Thus, in order to fully appreciate the relative importance afforded to changing nursing practice and education and the chaos which may ensue, it is necessary to understand the role of tradition and the comfort of certainty which is its result.

This paper aims to explore the binary opposition of the traditional role versus the emergent patterns for nursing work in complex adaptive systems that will inform the creation of curricula based on a challenge to nursing currency or value.

The Role of Tradition

In order to meet the challenge to nursing's value, nursing education, at all levels, may be required to prepare the professional nurses of the future to manage uncertain situations in which the traditional ethos of the nurses may be retained although the role, function and practice are not.

The roots of nursing education lie in the form and content outlined by Nightingale in the mid-eighteenth century in England. Nightingale's scheme of training put her probationers under the direct supervision of a ward sister who was responsible for the training and assessment of nurses, typical of "apprenticeship" training (Bohnam-Carter, 1867). The similarity to both the form and content of these initial schemes of training programs of nurse education today is compelling (Benner et al., 2010). Although Nightingale and her contemporaries stressed the importance of personal qualities such as sobriety and hygiene, notions of caring and interpersonal relationships were introduced both at that time and later into the collective psyche of nursing. An example of the work of the student nurse in the United Stated nursing education system in the mid twentieth century is a mirror on the past, reflecting congruence with the experience of "apprentice" nurses in the late 1800s (Bohnam-Carter, 1867; IOM, 2010, p. 527; Benner et al., 2010). This is witness to the international influence of this pattern of nursing tradition established in the latter part of 19th century England. Further, it is worth noting that the relationship between doctors and nurses was both established and reinforced by Nightingale. Although she believed that nurses should organize and discipline themselves, Florence Nightingale nonetheless saw nurses as being there to carry out doctors' orders (Bohnam-Carter, 1867).

It is a moot point whether there has been a conscious effort on the part of nursing practitioners and educators as to which, if any, aspects of the traditional nursing role, function and identity should remain and which, if any, should be reshaped. Traditional definitions of nursing have been stable for a long period of time and others in healthcare have come to depend on the meaning of nursing without questioning the vastness of what nurses can do for the care delivery system. This traditional definition of nursing acts as a tether for nursing, causing a pull towards the binary pole of tradition. This is, in part, due to the external historical and socially constructed forces that have defined nursing within systems, but also to some degree to the nurses' traditional internal constructions, resulting in the current valuation of the nurse.

It would appear to be evident that, as nursing curricula are created, a clear view of traditional nursing identity and currency has been established which forms the basis of certainty for this foundation. Nursing continues to hold onto very old constructions and has largely educated to this valuation. This suggests that the traditional view of nursing is the concept which has been offered the position of power by healthcare systems over more progressive views of nursing and curricula which inform contemporary practice. However, this value may require to be modified since the evolutionary process into which nursing is being thrust is causing disruption of our work environments, causing a push to a contemporary way of nursing. As yet, it appears to be the case that there is a lack of courage to leave off what was defined as the basic functions of a nurse from the education of nurses. From this position of tradition and certainty, "training" of the nurse to undertake a traditional role continues to be emphasized rather than developing curricula which emphasize what nurses need to "learn" in order to respond to the disruptive chaos of our complex health care systems (Benner et al., 2010; Brenner, 2012).

In complexity, we are compelled to find new ways to notice, interpret and respond to patterns as we create a more ordered system, a process which compels the student to learn and the teacher to provide a learning environment. Algorithms of order and tradition do not apply since nurses cannot "train" to work in complexity or chaos. Complex adaptive systems are dependent on historical learning and events that contribute to the set conditions that define the situation (Olson and Eoyang, 2001; Clancy et al., 2008). Therefore, each pattern or event emerges anew, situated in a historical context and with new complex processes and structures that often confound the responders.

Shifting Identity

Healthcare systems internationally have been built, operationally and socially, around the traditional constructions of how nurses are; and the evidence demonstrates that these systems have not made accommodation for nurses to evolve as the complex adaptive health care delivery systems morph and uncover emergent issues and patterns. This is additive to our internal constructions of value of the self as a nurse. The binary pair of terms represents the traditional versus the contemporary definitions of how nurses are perceived in society and what nurses do, perceptions and actions, which are required to change if a new identity is to be forged and nursing revalued. Dynamical relationships with all actors remain to be created in the face of the two poles of tradition and progress pulling against each other.

This process of morphing professional roles and identities has historical precedence. Wilensky (1964) notes that as roles and identities are being defined and organized within an occupational hierarchy, there is a tangible "sloughing off" of responsibilities from one tier within the hierarchy to those that occupy the group below. This relationship is symbiotic: for the professional group who release the skills and tasks, they may gain the ability to shape both their own professional group and that of the group below them in the hierarchy. For the occupational group who take on the skill, they are afforded some of the recognition given to the higher group. Thus, within an emergent health care system with a requirement for a shift in care delivery, there is the creation for the opportunity for new professions (e.g., the nurse practitioner) to take on the "sloughed off" responsibilities from medicine and, in turn, for nursing to divest skill and responsibility to groups below them in the hierarchy, for example certified nursing assistants in the United States and healthcare assistants in the United Kingdom. The authors hope that the binary poles of traditional vs. contemporary work of the nurse move from a hierarchical structure, with the traditional way in the superior position to a balanced linear structure with the two