The new graduates' professional inheritance

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NEW GRADUATES' PROFESSIONAL INHERITANCE

Across North America, health care systems are experiencing an escalating shortage of qualified and committed registered nurses (RNs).[1,2] There is mounting evidence that the perception of nursing as a challenging, satisfying, and fulfilling vocation by society's youth is waning. The effect on health care workplaces is an increasingly limited pool of RNs available to fill nursing vacancies that crosses cultural, geographical, and economic boundaries.[3]

Amidst this crisis, health care communities continue to be challenged in their attempts to understand what constitutes a quality acute-care working environment. The question that underpins the growing nursing crisis is how to provide a working context for nurses that fosters quality healthcare consistent with the values of the nursing profession.[4,5] Recent reports of multinational nursing workforce trends revealed remarkably consistent symptoms of distress in the health care system. These are suggestive of: (1) fundamental problems in the design of nursing work, (2) inadequate staffing quotas available to cope with elevated acuity and census figures, (3) escalating worker absenteeism and costs of nursing care, (4) qualitative evidence of healthcare administrators being out of touch with the voices of struggling nurses, and (5) statistical evidence of job turnover and attrition amongst younger and newer nurses.[6,7]

Recent figures on nursing retention reveal that 35–61% of new nursing graduates (NGs) can be expected to change their place of employment, or leave the nursing profession altogether, within the first year of professional practice.[8] Unless steps are taken to understand the historical, social, and political context that has propagated and continues to sustain a stressful, oppressive, and traumatic acute-care environment, the high turnover of new nursing staff is likely to continue.[9,10]

The experience of the transition to professional practice for NGs in the Western culture has been reported in the literature, most notably in the works of Olesen and Whittaker[11] and Kramer.[12,13] It is disheartening to note that almost 40 years after Olesen and Whittaker's *Silent Dialogue*, and the introduction of the cultural construct of *reality shock* in nursing, many aspects of this topic continue to affect the current transition of NGs to professional practice.[14-16] Though the meanings of the similarities that exist among the most current generations of NGs to these historical findings remain speculative, they should pique our curiosity about the reasons for a continually chaotic and difficult transition experience. The most difficult elements of transition continue today in spite of significant advancements in the educational foundation and practice of nursing. In fact, transitional problems uncovered 40 years ago continue despite enhancement of healthcare delivery methods and technologies, as well as a predominant emphasis on quality care management throughout the acute-care setting.

A HISTORICALLY SITUATED OVERVIEW OF ACUTE-CARE NURSING PRACTICE

Modern Westernized healthcare is purported to have evolved from a primarily patriarchal-focused, physician-driven discipline of curing, to an industry that is collaboratively administered, community health-driven, and multi-disciplinary.[1,17] Though admirable in its upsurge from a medically, male-dominated beginning, an indigenous paternalism continues to reign within the structure and culture of hospital-based healthcare. Remnants of omnipotent oppression continually undermine the liberation of nursing as a profession, and reduce the effectiveness of current reforms in healthcare delivery.[18]

As a profession, nursing is historically situated and currently sustained within practical, social, and political contexts. Differing, and potentially opposing roles, philosophies, and expectations exist within these contexts. A brief review of the evolution of professional nursing alongside the transforming definitions of health and healthcare delivery provides a useful framework for exploring how nursing relates to itself and other health

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professions. These insights can further inform the current crisis in care that looms as health care workplaces meet the difficult challenges of recruiting and retaining a critically thinking, motivated and committed nursing workforce.

Nursing as Practical

The historical beginnings of nursing practice in the 1860s–70s were clearly charted as being within the context of a woman's duty to care for others.[19,20] Nursing practice roles were conventionally viewed as "embedded in the seemingly natural or ordained character of women, an important manifestation of women's expression of love of others, and thus integral to the female sense of self."[21] Because nursing was viewed by some as a subordinate augmentation of medical practice and provided support for the physician's needs, nursing was conveniently tailored to emphasize practical domesticity rather than theoretically based science.[22] During the early 19th century, nursing appeared privately in the home.[23] Nursing care involved the non-scientific provision of basic personal human care embedded within a moral framework of strong Christian values.[23] Nurses addressed the individual and collective problems created through the circumstance of illness by supporting personal resistance to the ravages of disease, and controlling the environment within which that disease reigned.

During the mid-19th century, the construction of hospitals was "a regrettable but necessary means of caring for the poor."[24] Support for these institutions originated from a mixture of charity and a need for the social control of "potentially dangerous lower classes."[24] Nursing in hospitals during this period was equally motivated by "poor, isolated women, unable to support themselves by any other means [who] sought, through hospital service, a bed, meals, and subsistence for themselves."[24] Male physicians and hospital administrators controlled the role delineations, decision-making, and clinical directions of these institutions, thereby crystallizing the deference and subordination of nursing to the professional authority of others. The origins of nursing practice during these early times were clearly linked to gender-based and class-sustained prescriptions of social worth.[25]

The early 20th century sparked an interventionist, disease-specific model of medical care delivery based upon the success of the germ theory in explaining infectious illness. As healthcare moved into the "modern" hospital, nurses were once again positioned to support the diagnosis and treatment paradigm intended to serve the advancing science of medicine.[23] According to Melosh,[26] advancement of the nursing profession was predominately facilitated by the dramatic changes in health care delivery orchestrated by the organization of hospital care. In recent times, a shift in the economic and social arrangements of power and control within healthcare disciplines has occurred, led in part by the shortages of nurses for hospital work and a growing discontent among women regarding their restrictive social position.[26]

Despite the appearance of favorable contributions of hospital care in advancing the cause of nursing in the early-to-mid-20th century, notable healthcare historians highlight how nurses continued to be structured within a heterosexual matrix as the symbolic "wife" to the doctor "husband," tending the patient "child."[27,28] These traditional gender-role prescriptions for behavior trapped nursing in an inter-professional dynamic that assured its task-ordered subservience to physicians. Schools of nursing attempted to imbue their female students with the suggestively intentional misrepresentation of the Christian roots upon which nursing "care" was founded. The characteristics essential to the "true woman" (piety, purity, domesticity and submissiveness) "were thought to be appropriately expressed in the nurse.[29] This construction of the 'ideal' nurse, sustained through decades of health care subordination and gender-based inferiority, has indeed created the 'mythical' nurse".[30]

Melosh[31] depicts nursing during the early period of the 20th century as a profession inevitably advancing on the wave of social permissiveness granted to women by virtue of the feminist movement.[32,33] Others have described the feminist movement and the evolving nursing profession at conceptual odds, as attempts to expand the social options available to women clashed with the threads of domesticity inherent in historical nursing roles.[24,30,34] In addition, it has been suggested that the professionalization of nursing practice has struggles to balance nursing as a valid science with the humanistic art of the profession. The science of nursing, including cognitive and technical task responsibilities that require a distinct specialized body of evidence-based knowledge, competes ideologically with the humanistic art of nursing care that seeks to validate and qualify the phenomenological aspects of the human illness experience. According to Melosh,[31] nurse leaders (educators and administrators) have distanced themselves from the direct-care worker. This has occurred through their pursuit of an "either/or" professionalizing strategy based upon advancing nursing theory, education, and research at the expense of reducing respectability and credibility within the role of the clinical nurse. The inherent hazards of professional 'ideologizing' include alienating the mainstream of the nursing profession and creating a theory-practice gap. Other dangers include increasing intra-professional anti-intellectualism and interpersonal conflict commonly found in oppressive group behaviour.[35,36]

The movement of healthcare delivery toward the profit-orientated, secularized capitalist agenda that is now the cornerstone of Westernized social structure contributes to distortions of this ideology for nursing. It

seems that the focus on what can be economically "gained" (or at least not "lost") through healthcare delivery as a vehicle of market-earning power, dominates the current trend. This shift has reduced the value placed on the altruistic and humanistic intents that have historically characterized, and continue to form, the underlying foundations of nursing's moral imperative to care. Caring, in the context of acute-care healthcare delivery today, has been perversely associated with outcomes that are dependent on treating illness rather than optimizing health. This emphasis potentially leaves the public vulnerable to a healthcare framework based on politically and economically driven demands for the advancement of science and technology. The socially motivated call for holism and mutuality, or the moral conditioning that comes with a sense of communal responsibility, becomes progressively unfashionable.

Nursing as Socio-Political

Nurses constitute the largest health care profession in the world, with the majority of those nurses employed in hospital environments.[18] The nature of acute-care nursing work predicates intimate partnerships between nurses, interdependent working relationships with physicians, and unprecedented levels of occupational intimacy with the public. Understanding the intricacies of these inter-personal and inter-professional links may provide a realistic and much needed framework for comprehending the struggles of the NG in establishing and maintaining these important relationships.

Nurse-Nurse Relationships

The interactions that occur between nurses are complex and multifaceted. Nurses develop and maintain relationships individually, as colleagues and partners at the level of healthcare delivery, and collectively as political allies and champions of a holistic, comprehensive, and globally sustainable approach to health. An internationally shared culture of professional nursing values exists, with dominant features that characterize the nature, essence, and prevailing attributes of the nursing profession.[37] Leininger suggests that subcultures or specialties in nursing, such as acute-care, might manifest qualities and behaviors that differ, and possibly even conflict, with traditional mainstream professional values. Increased levels of patient acuity and ever-increasing costs associated with caring for sicker patients place substantial fiscal pressure on many acute-care institutions. Subsequently, nurses are continually pressured to "do more with less." Such requests render caring for patients an increasing challenge, and escalate the practice tensions that currently exist in an overburdened acute-care workplace.

Numerous authors have detailed the argument that nursing is an oppressed group.[38-40] This claim is based on the supposition that nurses have internalized the values of physicians and the medical model of acute-care they work within. The ramifications here are that nurses find it difficult to identify with the characteristics or intents upon which their nursing education and professional socialization were ideologically based. Oppressed group behavior, in the form of self-hatred and interpersonal conflict, is claimed to be evident in nursing at many levels. These include: intra-professional dissension and hierarchically-oriented aggression; a lack of professional identity and group cohesion; and acts of submission to more dominant health care professions such as medicine.[35]

Nurse-Physician Relationships

In the early 1960's, Stein[41] offered a provocative glimpse into inter-professional boundaries through what he coined the *doctor-nurse game*. Set in the context of hospital care, this relational framework served, and some suggest continues to serve, as the principal foundation for communication between physicians and nurses.[42,43] Based upon the predilections of medical superiority and nursing subservience, the object of the game was for nurses to communicate practice recommendations to physicians without subverting the physicians' self-importance and sense of practice omnipotence.[41] Evidence supports nursing's ongoing "occupational subordination to medical dominance,"[44] though the nature and presentation of the distortions in relating have become more covert and increasingly disturbing to nurses.[42]

In research on the doctor-nurse dynamic of the mid-1990's, Wicks[45] argued that nurses continued to be rendered passive in their relationship to physicians. Previously, Skillings[46] claimed that these oppressive relationships result from an organizational environment where nurses "get their hands dirty. . . [while doctors] stand off and look at what's happening."[46] During this same period, authors have also articulated how the persistent and historically resilient doctor-nurse subordination puts the acute-care nurse in the position of having to "cooperate in the construction of an elaborate facade, the function of which is to hide the degree of skills, knowledge and information [nurses] possess."[47]

Nurse-Society Relationships

Society's opinion of an occupation is of great significance to its membership, affecting the individual as well as the collective self-appraisals of the occupation's members. Passau-Buck and Jones[30] claimed that society has been deceived into believing that nursing and medicine are very similar; that nursing skills are attributed to medical skills, and that healthcare and medical care are interchangeable terms. Nursing in the early-to-mid-19th century was considered by society as a calling for women. This notion stemmed primarily from its historical and, to some extent, continuing ideological association with religion and vocation. The religious/

vocational association has perpetuated the commonly held societal notion of nursing as a “charitable and merciful gesture to mankind.”[48] Indeed, it is claimed that the medical profession “created and continues to support the societal view of the nurse as the physician’s helper, there simply to carry out the physician’s orders.”[30]

Since the early 1900s, decades of social change have engendered a kaleidoscope of freedoms and opportunities for women. The consequences of gender-based social change have afforded nurses a place in higher education and an expansion of their roles as advanced practitioners.[49] Despite this, nursing continues to struggle to sustain the practical applications of its virtuously-based moral imperatives. The ongoing reality is that nursing represents a feminist ideology of caring, nurturing, holism and inclusion that is essentially devalued within a male-oriented social and political institutional structure. Such a framework continues to emphasize reductionism, isolation, individualism and the exclusionary application of “illness-focused” technologies.[44] This reality continues to undermine the practice environment of current hospital-based nursing.

ACUTE-CARE NURSING TODAY

Regardless of evolutionary advancements in the foundational education and practice of nursing, enhancement of healthcare delivery methods and technologies, and a growing emphasis on quality care management, it is increasingly challenging to work as a nurse in acute-care settings today. Nurses suffer from the highest levels of stress of all health professionals, as evidenced by higher rates of absenteeism from unprecedented levels of injury, illness, stress, and burnout.[50,51] The contemporary hospital environment is intense and complex, with potentially unrealistic acute-care workloads and inadequate support for the professional nursing role.[52] It is not difficult to understand why nurses express increasing dissatisfaction with the level of care they are able to deliver, and the quality of the environment in which they deliver it.[51]

While enhanced knowledge of the sciences which support nursing practice have allowed a broadened scope of response and intervention, the concurrent increase in patient acuity has dictated changes in nursing roles and responsibilities that potentially reduce the quality of the care delivered. Nurses are being asked to do more with less. For example, nurses spend insufficient time in therapeutic relationships with their patients, and have fewer opportunities to engage in quality nursing interventions that can address the plethora of clinical complications arising from patient populations that are increasingly complex.[53] Less time is afforded to the nurse to engage in relational and supportive interactions with patients as time is spent addressing clinical complications that arise from a census of more acutely ill patients. These higher levels of responsibility without equivalent increases in practice autonomy and patient contact increasingly frustrate nurses.

The increased reliance on non-regulated nursing groups (LPN’s, care-aides and orderlies) relative to the appropriate utilization of the cognitive ability of the RN are examples of how cost-cutting administrative decisions continue to dilute the support for the professional role of the nurse.[53] Further to this, the role of leader, preceptor and mentor, traditionally filled by nursing managers, has been gradually eroded. Human resource and workplace quality management, which were once the domain of nursing management, have given way to issues of capital resource allocation and fiscal responsibility.[54] The potential effect of such changes is to turn direct-care nursing into more of a “hit and run” series of detached and task-oriented interactions with patients, leaving nurses feeling “devalued, abused, powerless, and with a pervading sense of moral dissonance related to their practice.”[55]

The acute-care setting continues to be dominated by Medicine, thereby reducing the autonomy and role fulfillment of bedside nurses.[56] Such domination can perpetuate nursing’s clinical decision-making dependence on a discipline that is unaware or unsupportive of the preventative, caring and curative scope of nursing practice in current healthcare. The ongoing struggle to gain nursing autonomy coupled with the current nursing shortage should be considered part of “a healthcare system that refuses to recognize [it’s] . . . oppressive hegemonic and misogynistic practices.”[57] Indeed, these practices continue to maintain and perpetuate the powerlessness of a nursing profession that is predominantly female. The world-wide shortage of nurses may continue, and possibly escalate, in the near future.[56] However, recognition and support for professional partnerships in health care provision based on autonomous and collaborative practices, is likely to encourage nursing recruitment and retention by fostering equality in health professional relationships.

THE NEW GRADUATE IN ACUTE-CARE

Newly graduated RNs are entering professional practice at a tumultuous yet potentially exciting time in the evolutional history of healthcare and nursing. Highly educated and armed with considerable nursing knowledge and an intolerance of the previous “sink or swim” management style of many recruiting institutions, the newest generation of nursing recruits is coming into the workplace with greater loyalty to the profession than the employing agency.[55] The newest working generation is reputed to have higher self-esteem than graduates of other generations, and has an unwillingness to tolerate a patriarchal and medically dominated health care management system that has historically sought to devalue nursing care as “women’s work.”[58]

The socio-cultural factors and political circumstances that persist within the acute-care nursing environment can potentially alienate the NG early in their socialization to professional practice.[59] New graduates may experience inherent value discrepancies between the academic environment in which they have been "raised," and the industry into which they are being initiated. At the same time, new nurses are being recruited into practice areas where unprecedented workload expectations are meeting work environments with high stress levels that have exhausted the experienced nurse to whom the NGs turn to for mentorship and role-modeling.[60] In the worst case scenario, the professional practice standards and anticipated professional realities being brought to the acute-care environment by the NG can be severely challenged by the strains of practicing in the "real' world."

The term "reality shock" describes the discovery that school-bred nursing practice values conflict with work-world values.[13] Kramer's research suggested that nursing students were inadequately prepared to make sense out of, or subsequently be acculturated into, the behaviors and expectations of their new professional culture. Despite the 4 decades that have elapsed since Kramer's[13] original work, current research supports the contention that the primary challenge for the NG lies in their struggle to reconstruct a new professional sense of self that fuses the ideals of their education with the realities of their practice context .[61,16]

Idealistic and motivated NGs begin their careers with high professional expectations coupled with little practical work experience. These new nurses may lack the professional maturity needed to navigate the complexities of the contemporary acute-care workplace. NGs are functionally unfamiliar with the realities inherent in practicing as a responsible nursing professional and may be somewhat intimidated and daunted by the seasoned practitioners they perceive as "experts." Initially, NGs may feel ill-at-ease within an organizational culture whose focus and intensity seem harsh in comparison to the protected perspective of reality acquired as a student. The socialization process demands that the NG quickly gain the respect and admiration of colleagues whose acceptance is critical to their professional development.[54]

It has been suggested that the first year of professional nursing practice is similar to an obstacle course, with graduates experiencing their work as traumatic primarily because of unrealistic management expectations that the NG will "hit the ground running."[62] The nature of the unrealistic practice expectations by senior nursing staff, relative to the NG, may emanate from veterans that have had to adjust to an excessive workload and responsibilities. These experienced nurses may have accepted the socio-culturally and politically oppressive context of acute-care nursing as normative, and desensitized themselves to the impropriety of some of their assimilated, or even abandoned core nursing values.[63,64] A recent qualitative exploration of NGs in acute-care depicted an intriguing set of divergent practice standards that left the new nurses feeling disillusioned, disappointed, and detached from the practice environment.[10] Participants in this study claimed to be caught in moral practice dilemmas where they were expected to choose between: (1) caring effectively or caring cost-efficiently, (2) providing comfort and meeting the needs of their patients or maintaining a rigid organizational structure and ordered routine, and (3) practicing their nursing education ideals or assimilating the institutionally modified, and often minimum, practice standards of the health care industry.

Significant stress for the new recruit has been identified as deriving from their anxiety-laden relationships with seasoned nurses and physicians.[51] In recent worldwide studies, some NGs have described an acute-care working environment that is antagonistic, unwelcoming, abusive, resistive to new ideas, and fraught with negative attitudes about nursing and healthcare.[65,66] In addition, some NGs continue to describe the historically based pressure to conform to unit routines set within a rigidly standardized hospital bureaucracy. This context of practice may be understood by the NG as ritualistic and as interfering with their ability to interact with and meet the needs of their patients.[54] Significant to this perception, and to nursing retention, is the sense of violation experienced by these new practitioners relative to their strong sense of professional integrity.[35] The moral dissonance caused by the incongruities between their anticipated practice standards and those that they see modeled for them in the "real" world could result in a sense of personal moral outrage. This divergence has been shown to translate into a prevalent belief that ethical compromise is unavoidable in hospital nursing.[64] This may further contribute to a pervading frustration with seasoned nurses and managers whom the NGs perceive as having resigned themselves to an unacceptable level of compromise in the practice of their profession.[67,54]

New Beginnings

Amidst the potential for turmoil, stress, and burnout in acute-care nursing workplaces, many enlightening strategies are continually evolving that specifically recognize the professional socialization needs of NGs. There are a number of nursing workplaces worldwide that have begun to lead the way to nursing's future by carefully examining nursing's historical development and the myriad of socio-political influences on both the nursing profession and the health care industry. The magnet hospital philosophy[68] is one good example of attempts to redress what some may claim is a "toxic" work environment for nurses. The intended imperative from these nursing workplaces is an ongoing commitment to career pathway development, structured and

resourced mentoring for nurses of all levels, and a commitment to a nursing environment that actively supports nursing autonomy, recognition of professional status, and advanced nursing practice and education.

Strategies aimed specifically at NGs can have a spill-over affect for all members of the nursing team. These may include: the committed and resourced development of preceptor programs, the promotion of critical thinking by developing a nursing workplace culture that encourages challenge, change, and ongoing knowledge development, and the support of a realistic contemporary nursing image by encouraging membership in professional organizations and nursing groups in the workplace and community.

Professional socialization is currently challenged by incongruities between education and industry, difficulties in formalizing appropriate administrative and functional support for the NG, and a growing expression by nurses of powerlessness within the health care system. Educational institutions, health care facilities, and the administrators responsible for the basic education and practice integration of NGs into the nursing workforce must acknowledge, understand, and work to resolve the oppressive socio-political context of the hospital environment if we expect to replenish and retain a motivated and energized nursing workforce.

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