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Abstract

Formerly playing an assistive role motivated by virtue, obedience, and self-denial, nurses are now autonomous professionals with unique expertise, skills, and competencies. However, current recognition of the nursing role is far from optimal and perpetuates the invisibility of nurses' real work. This article examines one component of the situation: the non-recognition of the nursing role by nurses themselves. Hypotheses explaining this phenomenon, like the history of nursing and the lack of common language, is presented, as well as its impacts, followed by exploration of possible solutions.

Key Words education, history of nursing, language, nurse's role, vocation

Ending the invisible work of nurses: Reflection following a study about nursing support of relatives

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Nursing profession has evolved considerably since Florence Nightingale and religious orders, assistants and care attendants providing care. Pioneering nurses, as well as the possibility of university education among other things, have advanced the role nurses play, from that of medical assistant to autonomous professionals with distinct knowledge and skill sets whose expertise is complementary to that of other health care professionals.

In furthering the nursing profession and discipline, the importance of defining the essence of nursing has been advocated for decades.[1, 2] Clinicians, theoreticians, and researchers have strived – and continue to strive – to define the field of nursing and nurses' role and responsibilities.[1] Despite such advances, the value of nurses' work and nurses' key contributions to individual, family, and community health are still not always adequately recognized; such contributions are, in fact, often undervalued by the population, the media, and even within the health care system itself.[3]

As of 2021, in the midst of the Covid-19 pandemic, nurses have been on the front lines for months in an essential role. But, as argued by Waddell et al.[4], even though "[their] heroic actions (…) have been well covered during the pandemic, in the end, nurses were portrayed as victims, not as leaders" (p.3). The pandemic also putted forwards the superhero or angel narrative for nurses, which is not the recognition that is helpful to the nurses' position in the health care system and politics. First, it hides the problems related to the lack of nursing staff and resources, present for years, long before the pandemic.[5] Superheroes don't need staff or resources because they are sufficient at resolving problems on their own. Then, it takes away the emphasis on the skills and knowledge of nurses to

put the spotlight on the vocation and their courage, which are words frequently used to talk about nursing. So the problem of non-adequate recognition persists.

We postulate that one of the golden rules of receiving adequate recognition is first knowing one's own worth. The minimization of the nursing role and nursing interventions by nurses themselves certainly contributes to perpetuating such nonrecognition. This nonrecognition has a major impact on the role nurses play and the power they hold in the health care system, on negotiating fair working conditions, on defining and recognizing their role, and even on the professional acts they may perform.[6] Therefore, based on examples from practice and research with nurses, this article aims to reflect on how nurses conceptualize and discuss their own clinical practice, the reasons and impacts of those conceptualization, and to suggest some possible solutions.

Ten relatives and nine nursing home nurses were interviewed during a study that aimed to propose an inductive theory of nurses' support of relatives making end-of-life decisions for residents living in nursing homes with a major neurocognitive disorder (for complete methodology and results, see [7]). The process of recruiting participants for this study was difficult at times. Many nurses considered that the responsibility of supporting relatives in the process of making medical decisions around residents' end-of-life fell to physicians and, consequently, these nurses said they did not intervene on that subject nor did they discuss those matters with relatives. Even nurses who agreed to participate in the study expressed, from the very first contact with the interviewer, their doubt about being able to help the researchers since they felt it was the physicians who assumed this role in their institutions. When signing the informed consent form, many of these nurses expressed their fear of having nothing to say on the subject, so much so that even the most experienced researchers would probably have questioned the relevance of proceeding with the interview and even the relevance of the research project itself.

Yet, the collected data was rich, from the very first interview with a nurse. Even though she claimed she did not offer relatives support in decision-making situations, in fact, it turned out that she intervened in ways that were key to relatives' decision-making process on a daily basis. By exploring relatives' fears, educating families, or intervening in other specific and intentional ways, the nurses were indeed making essential and obvious contributions that supported relatives in their decision-making process. However, one nurse-participant after another expressed, sooner or later in the interview, this same perception of not being involved in supporting relatives. And interview after interview, their answers to the researchers' questions showed exactly the opposite: the nurses' intervention strategies were quite specific and these relied on strong clinical judgment and advanced expertise, knowledge, and skills in end-of-life care, neurocognitive disorders, and family care. So, how can we explain this blatant disconnect between what nurses said they did and what they actually did?

Buresh and Gordon [8] discuss the phenomenon of how nurses minimize the importance both of their interventions and of the impact and central role of these interventions in maintaining patients' clinical condition. Multiple examples of nurses attributing the success of care to other professionals or to relatives' excellent bedside support further illustrate the phenomenon. The authors question why nurses downplay their expertise and find it difficult to recognize their skills and clinical impact.

Buresh and Gordon go on to shed light on the disciplinary discourse conveyed to the public that emphasizes virtue over knowledge and skill. This position would seem to be rooted in a religious history that has strongly influenced the development and values of the nursing profession. This might partly explain the observed phenomenon. Indeed, when nursing interventions were assumed by nuns, obedience, self-denial, and invisibility were among the expected "qualities" of nurses. It would seem that vestiges of this heritage are still be seen today, as nurses seem to still be influenced by the notion of virtue, which they have internalized. As Buresh and Gordon mention, "One way to avoid the danger of 'pride' is to give the credit to someone else".[8] In other words: nurses' work often remains invisible.

Other authors point to oppressed-group behavior to explain this invisibility. Developed by Freire [9], this concept states that in a given culture, a dominant group promotes its main characteristics as the only valid ones, to the detriment of the dominated group whose attributes are devalued[10] The dominated group comes to believe in its inferiority and find themselves in a state of obedience, silence, and invisibility, unable to make their needs heard and thus, rendering them unable to rise out of this dominated position.[11] It is possible that the dominant biomedical model sometimes places nurses in a position of inferiority. Nevertheless, the essential role nurses play in the evolution of patients' state of health is obvious, as illustrated in Adams and Nelson [12]:

> Physicians typically see patients only periodically and for short periods of time. Acute care nurses, on the other hand, are responsible for keeping people – often extremely fragile people – alive, comfortable, and on the path to healing twenty-four hours a day.

> In community care settings, nurses are likewise often responsible for ongoing monitoring, education, and assistance. The skills necessary for these practices do not simply arise "naturally" from a sense of sympathy, nor are they merely a somewhat degraded subset of the physician's skills. They are distinct, nursing skills acquired by nurses through education and clinical practice (p. 6).

Thus, some of the competencies nurses utilize to effectively intervene with patients are well defined, recognized, and valued most of the time. An example would be the skills and abilities enabling them to intervene effectively in situations of respiratory distress, hemorrhage, or when an alarm sounds on a patient's heart monitor. However, this is perhaps less the case for other components of the nursing role, especially those that are not quantifiable or that are difficult to measure. Henry [13] mentions the strong correlation between what appears on patients' charts (i.e.: quantifiable or measurable interventions) and what is perceived as fundamental to the nursing role, by nurses themselves but also by other professionals, administrators, and politicians. At the same time, the predominance in the current health care system of the biomedical model, its technical activities, and its language – in Canada at least and in many other countries – seem to overshadow any interventions that do not correspond.[14]

As a result, nurses can perform blood tests or administer treatments according to specific and measurable parameters, objectively recognize the results and their impact, adjust their interventions accordingly, and document it all in patients' files. However, nursing interventions devoted to coordinating and conceptualizing care, ensuring patients' safety and ongoing evaluation so as to be able to intervene quickly in the event of deterioration, supporting patients and their families in understanding the diagnosis and the treatments offered, reassuring relatives, etc. are difficult to quantify or measure. Most of the time, such interventions are not documented on patients' charts.[15] But all these interventions and many others are part of nurses' day-to-day work and are vital to patients' well-being and even survival. If these interventions are neither quantified nor measured, they do not appear on patients' charts and are also downplayed by nurses themselves, how can the full nursing role be recognized at its true value?

A recent conversation at the nursing station of a palliative care home is a good anecdotal illustration of the issue. When a nurse offered her help to coworkers, one immediately replied she did not need any help; her shift was so quiet she had just spent 15 minutes "chatting" with a patient's family. Asked what she meant by "chatting", she explained that she had opened a discussion with the family about how they experienced their mother's admission into palliative care. As a result, she learned that the elder son was struggling, while the younger son, who is uncomfortable with expressing emotions, did not wish to receive support, and that there was significant conflict between two other family members. All of this data allowed the nurse to adjust the patient's care plan accordingly and propose appropriate interventions to continue her care. Those 15 minutes were therefore anything but "chatting"; indeed, they were an important nursing intervention that would affect the very conceptualization of care for the patient and her family. So why did this nurse say she had "chatted" with the family, rather than claiming to have carried out an intervention with the family? What weight does each definition of these 15 minutes carry in understanding and explaining the nursing role?

Even from a strictly economic perspective, the allocation of funds to 15 minutes of "chatting" is by no means justifiable, whereas the actual intervention carried out was well worth such expenditures. Adams and Nelson [12] underline that a common and specific language is fundamental to better articulating the nursing role, in order to access economic resources that are appropriate and match the value of the work. In other words, the language used to describe nursing interventions has a significant impact on the recognition and value given to this work. This is also the case for the support given to relatives in an end-of-life decision-making process. Indeed, why should investments be made to train nurses in best practices if they themselves claim—and wrongly so—that they are not involved in this essential work? Could it be a case of what Watson [16] calls "the identity and boundary dilemmas" (p. 38) where nurses have difficulty finding the words to describe their role and in differentiating their unique contribution to the health care system from those of other professionals?

Ultimately, the questions are: How can nurses recognize the crucial nature of all aspects of their role? How can they adequately and accurately articulate their full role and interventions, in order to take their rightful place in the health care system and in the political sphere?

First, nurses from all areas of practice should ask themselves these questions—and, more broadly, reflect on the impact of their current attitudes and discourses—in order to find innovative solutions adapted to the reality of nursing practice.

Daiski [17] stresses that "change, in order to be appropriate and effective, needs to come from within nursing, be brought about by nurses themselves, and be achieved through greater advocacy for the profession" (p. 48). Recognition of their own contribution to the healthcare system is also essential to the advancement of the discipline and the nursing profession. Nurses are therefore key in this situation. Even though the nonrecognition of the full nursing role is a multifactorial systemic problem, every nurse has the opportunity to be a catalyst for change. By changing their own discourse about themselves, their role and their contribution to healthcare, nurses will inevitably contribute to an improved collective recognition of the nursing profession.[18] Also, rising their colleagues' awareness of these issues should not be overlooked.

Second, change undeniably comes with education.[17,19] Buresh and Gordon [8] urge nurses to emphasize knowledge, rather than virtue, when communicating with each other, as well as with other health care professionals, administrators, policy stakeholders, the public, and the media. Education pertaining to nursing history, including gender-related power issues nurses have faced that shaped the past and present dynamics in healthcare, is also vital to nursing empowerment. [18] Education is not just for nurses; educating the general public and especially the media is also an approach to consider.[8] Indeed, the media image of nurses contributes to the persistence of the status quo, as does the absence or infrequency of nurses as experts in the media, which also hinders recognition of their expertise and contribution.[20]

Moreover, in better recognizing their contribution and defining their role and interventions, nurses would benefit from having access and utilizing available research results. Obviously, evidence-based practice should be the norm. Therefore, access to research results that map nursing interventions and give words to professional interventions would help nurses make invisible work visible – and unconscious work conscious – so that nurses appreciate the depth and extent of their daily tasks and interventions. For example, the results of our study identified aspects of the nursing role that were fundamental to supporting relatives' decision-making process. These findings could help nurses understand the essential part they play in this support and give them words to describe their interventions. Research in nursing and the reduction of the research-practice gap are indeed vital to giving nurses the tools they need to describe and fight for the recognition of their full scope of practice.

These possible solutions are a starting point for reflection. Effective intervention on a systemic problem requires approaches that identify and target the other problematic aspects that perpetuate the situation. This reflection should therefore be continued to identify tangible interventions that lead to recognition of the full nursing role. Among other benefits, this would give nurses better access to the human and financial resources needed not only to provide quality care but to influence decision-making as well as political and administrative spheres. It is the general public who will gain most from better recognition of the nursing role.

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