Professionalism: Myth or reality

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Have we as nurses deluded ourselves regarding our professionalism? We call ourselves professionals and interminably defend the development of our profession. Yet at the present time, we are still largely unsuccessful in actualizing a distinction between professional nursing and its technical counterpart. We have the mission, knowledge, and commitment for a vital professional service to society. Why then is it not a reality?

A professional relationship involves a direct connection in the form of an informal contract between the professional and the client for an identifiable service in a particular area of expertise. It is not bound by place or time. It requires knowledgeable judgment in a specific area. The client makes the ultimate decision whether or not the relationship occurs and is maintained.

A technical role involves the performance of repetitive tasks prescribed by and under the surveillance of a professional authority. The performance of these tasks requires specific knowledge and judgment. The place and time of the performance of these tasks is determined by the professional or institutional authority. Persons performing these tasks are readily exchangeable.

The law defining professional nursing incorporates a dependent function, the ultimate authority for which rests with the medical profession. Medical technology comprises the major portion of the practice of nursing in hospitals. Observation of the work of hospital nurses reveals primarily the performance of delegated medical treatments and observations with little or no specific nursing connection to the patients.

This was not always so. In the early history of nursing, nurses functioned relatively independently in direct relationships to individuals regardless of whether or not the individual had a diagnosed disease. Increasingly, however, nursing became more dependent on medical authority and hospitals for its practice. The momentum of our recent history has been to widen the dependent path by expanding the performance of tasks aimed at the diagnosis and treatment of disease (Orlando, 1987).

As I talk to nurses about their current practice (Newman & Autio, 1986). I am forced to conclude that the fulfillment of a professional role in nursing is largely a myth. Schlofelfdt (1987) too concludes that "nursing remains essentially an other-directed and controlled occupation, rather than a self directed profession."

A MATTER OF PARADIGM

Bruner (1986) suggests that myth serves as a substitute or filler for experience. Nurses who are committed to taking good care of patients and who work hard and
are skilled in what they do are convinced that they are functioning as professionals, in spite of the fact that their work more clearly fits the definition of technical practice. These attributes - human compassion, dedication, and technical expertise - are essential but not sufficient to characterize the whole of nursing professional practice. We have debated the issue of professional vis-a-vis technical for at least a quarter of a century, with little resolution. Recently I realized with astonishing clarity that the issue is not primarily one of professional versus technical. The issue is one of different paradigms of practice: person-oriented care in contradistinction to disease oriented care.

An editorial by Man Mallison (1987) called for recognition of the need for different types of practitioners with different types of education and for both types of practitioners to respect the abilities of the other. A reasonable exhortation, why haven't we been able to accomplish it? In order to do so we need to recognize that the barrier to valuing the role and education of each other is the fact that the different roles and educational programs emphasize different paradigms, different world views. The predominant practice perspective derives from the paradigm of health as the absence of disease, it paradigm in which the "battle" against disease is uppermost and the practice mode is one of dominance and control. The person oriented health paradigm, espoused by the nursing profession, places personal meaning and quality of life at the forefront and requires a practice mode of collaboration and mutuality. When one is viewing the world from one side, it is difficult to imagine, much less value, the view from the other side.

Schloftedt (1987) sees the perspective within which nurses view their world of work and inquiry as critical to the future of nursing. She points out that we are agreed that nursing's mission is the optimizing of persons' health. But there is where the agreement ends: Is this mission for all persons or just for those being treated for medical problems?

Divergent views on this issue indicate different paradigms of health. And different paradigms of health require different types of technology. If the institution is ruled by the medical paradigm, activities within that paradigm are the ones that will be honored and rewarded. Nurses functioning primarily in the medical model are operating in the currently, more powerful paradigm; those functioning primarily in the nursing model are addressing concerns that are viewed as nonessential extras by the prevailing paradigm. The "anti-education" bias that, Mallison (1987) refers to among practicing nurses is more a function of conflicting paradigms than of educational status. If it is important that nursing concern itself with both paradigms, then at least we should know what paradigm directs the practice.

Nursing roles within the hierarchy of medically oriented institutions are under the authority of medicine and the institutional administration. In the past, some of the professional priorities of nursing were integrated in this role. The current emphasis on cost effectiveness within institutions dominated by the medical paradigm accentuates the priority of the medical regimen in the delivery of care. and nursing practice within this system is diminished as nursing priorities fall by the wayside.

AN OPPORTUNITY TO ACTUALIZE PROFESSIONAL NURSING

The authority of a profession lies in its knowledge. The professional role requires, a direct relationship with the client on an ongoing basis. It permits relative autonomy in decision making based on tilt knowledge of the professional discipline.

The nursing void created by dominance of the medical model is making room for a new nursing practitioner who is responsible directly to patients for coordinating, their continuing care wherever they might be - in the hospital, at home, or in other health care sites. The functions of this nurse are not new, but the designated position makes it possible to actualize the essence of nursing in a direct connection to clients on an ongoing basis, regardless of

1For further discussion of the two major prevailing paradigms of health, see Chapter 30

2. This position has been referred to alternately as a patient care coordinator, continuing care coordinator and case manager. Although the case manager title gained more recognition, the term case connotes an impersonal approach and the team manager connotes one-sided dominance, both of which meanings are anti-theatrical to the person centered collaborative approach of the nursing paradigm.
setting, for as long as the client has a need for nursing care - a truly professional role that stems from the nursing paradigm.

The impetus for this continuing care role is the realization, both public and professional of today's general lack of personalized care and the tremendous gap in patients' ability to care themselves after hospitalization. Expanding hospital corporate structures now include the full spectrum of health care services, with increasing emphasis on home and ambulatory care; this expanded structure makes it possible to employ nurses in positions that span the various care settings. Private, insurance companies have moved ahead to provide reimbursement of long-term care, and governmental support will probably not be far behind. Professionally educated nurses are well prepared to relate to clients in ways consistent with the emerging paradigm of health and to collaborate with clients and other health professionals in the coordination of their care.

There is a common stereotype of technology as inhuman and concerned primarily with machines and techniques. This is the stereotype that nurses tend to reject. A more illuminating view of technology is stated by Eisler (1987), as "the use of both tools and techniques and our bodies and mind to achieve human - defined goals" (p. 55). The emphasis here is on human. This definition has meaning for nursing technology as we interact with clients on a human-to-human level and use ourselves as well as the knowledge and techniques at our disposal to assist clients in their health-related goals. A paradigm shift toward a collaborative model of practice based on person-centered patterns of health is occurring and when it establishes itself as the prevailing paradigm, medical technology will assume its place as an alternative within the whole, rather than as the primary focus. A shift in paradigm does not discard the old knowledge; it transforms it by viewing it from another perspective. If we are deal' on the perspective of the nursing paradigm, we can transform medical technology within the larger context of nursing.

We are at a turning point in the development of our profession. During the early first phase of our development, the knowledge of our practice was derived through intuition and qualities of human caring. As we moved into the second stage the medical paradigm dominated the education of nurses. The emphasis was on knowledge about disease, its recognition, and treatment. Emphasis was on finding out what was wrong and taking action to remedy the situation. The responsibility for performance of a large aspect of medical technology was delegated to and accepted by nursing. At the same time, nursing educators recognized the importance of knowledge about health per se and about patients as persons. In the current stage, as the transition to a person-oriented health curriculum takes priority, we are faced with conflict because the practice world is, still dominated by the medical paradigm, and we are uncertain how the transformation will take place.

**UNITED DIVERSITY**

We need to unite as a profession. We have bemoaned the confusion inherent in the statement that "a nurse is a nurse is a nurse." Now is the time to recognize the core of nursing in the various roles that nurses perform. Nurses have a perspective on health that is important and have a responsibility to society to be involved in the planning and coordinating of the continuing care of individuals and their families. Nurses need also to be involved in the direct day-to-day care, which incorporates medical and nursing technology. Nurses need to be involved in the organization and implementation of this care wherever it occurs. But the same nurse cannot do it all. One nurse plans and coordinate on a continuing long-term basis; another nurse organizes and coordinates the care in immediate short-term settings; and another nurse provides the day-to-day direct care in both institutional and home settings. The execution of these roles requires different types of expertise and different educational preparation. There is some consensus that the coordinator role, which spans institutions and settings, requires master's level preparation; the organizer/ supervisor role within a specific setting, a baccalaureate degree; and the direct care provider, an associate degree (Stull, Pinkerton, Primm, Smeltzer, & Walker, 1986).

In the past we have practiced an all-or-nothing approach in handling these responsibilities. Now we need to recognize the essentials of each of the above roles and the aspects that can be performed more effectively by each. This approach involves delegation, not in the traditional sense from top to bottom, but in the sense of shared and differentiated responsibility.
There is great dissatisfaction with the old system of health care and a need to burst into a new organization. Transformation will involve moving from a dominator model to a partnership model. The practice of nursing is not, as Mehanie and Aiken (1986) so ably put it, "the soft underbelly" of medicine but the mind and heart that makes transformation of the health experience possible.

CONCLUSION

Nursing practice is riddled with the problem of mixed paradigms. The predominant paradigm, health as absence of disease, is embraced by the medical model and incorporates characteristics of a paradigm or patriarchy such as dominance, power, efficiency, and control. The nursing model embraces a paradigm of dynamic patterning of relationships. It incorporates the feminine principles of caring, cooperation, collaboration, and mutuality. Nursing has been caught in a catch-22 situation. We have been mesmerized by the myth of professionalism in the status quo and have allowed our energy to be dissipated both in support of and opposition to the medical paradigm. It is time to recognize the values and directives of the nursing paradigm and move into the reality of our professional responsibility.