✠ SCHOLARLY PAPER ✠

Connecting conversations: Nursing scholarship and practice facing the 21st century

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An international inaugural conference held in Iceland in June 1995 had as its theme 'Connecting conversations: Nursing scholarship and practice into the 21st century'. In this paper, which is an expansion of my keynote address about this theme delivered at the conference, I begin by tracing the roots of both nursing's and wider society's separation and isolation and by identifying the forces that divide and unite us. I trace these roots through a more philosophical than professional or organizational lineage, examining how the culture of radical individualism and the modernist technological understanding may have forced this stance. I highlight what is happening in nursing at present and suggest pressures that possibly militate against collaborative and constructive 'connecting conversations'. I then move on to suggest some possible strategies through which we may begin to overcome the obstacles in the way of genuine collaboration and connectedness in our lives and work.

Key words: connectedness, individualism, nursing's future, technological understanding.

THE ROOTS OF SEPARATION AND ISOLATION

For nurses and the people they care for and with, these are both the best and the worst of times. Susan Phillips, in the superb and aptly titled *The Crisis of Care*, clearly set out the downside of the present age:

> *There is a crisis of caring for persons that cuts across the boundaries of the helping professions. Patients in hospital feel depersonalised and processed, students suffer from inadequate attention, clients wonder if therapists really care about them, and parishioners feel unknown in their places of worship. Caregivers are rewarded for efficiency, technical skill and measurable results, while their concern, attentiveness and human engagement go unnoticed within their professional organizations and institutions.*[1]

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The modern age is discussed constantly, but most critics of modernity agree that it is characterized by an extreme rationalism and rigidity, by an overwhelming tendency to order, to predict, to control. Max Weber understood that modernity was characterized by bureaucracy, the shining emblem of rationality.[2] Heidegger helped us understand how our modern era enframed and forced our world and often our very being into the narrow confines of a stultifying technological understanding.[3] This is not a knee-jerk stance of being 'against technology' but a recognition that our thinking and being are becoming more and more ordered and constrained. Dreyfus explained this succinctly when he noted 'Most recently, as we enter the final stage of technology, we experience everything, including ourselves as resources to be enhanced, transformed and ordered simply for the sake of greater and greater efficiency.'[4] Michel Foucault, too, warned us of the totallizing nature of the modern age, in his account of disciplinary bio-power, an all-permeating

power that is not located in a single person or structure but that operates down to the level of the smallest micro-practices.[5]

This 'technological understanding' is not an abstract philosophical concept. It has a real impact on every aspect of our lives, both personal and professional. The roots of our separation and isolation can largely be traced to the technological understanding of the modern era. This has corrupted rather than connected our conversations. It has created what Patricia Benner has called 'cathedrals of technocure' (pers. comm.) rather than hospitals and facilities that are places of compassion, re-integration, understanding and healing.

The postmodern turn in science, culture, philosophy and other domains challenged the illusions of a unitary and unified epistemological project that would establish 'givens' or indubitable truths. As Bauman noted, 'The illusions in question boil down to the belief that the "messiness" of the human world is but a temporary and repairable state, sooner or later to be replaced by the orderly and systematic rule of reason.'[6]

Postmodern thinking was to challenge these illusions by proposing (and celebrating) critical approaches based on deconstruction, radical uncertainty, ambiguity and difference. Nothing was to be as it seemed, and there was to be no Archimedean point of certainty on which to ground our thoughts and actions.[7]

THE PRESSURES ON NURSING AT PRESENT

Nurses in clinical practice throughout the world, however, must be wondering when the revolution of postmodernism will reach their world of the bedside, because they are feeling the brunt of the technological understanding, the economic rationalism and the scientistic thinking that is the hallmark of current political and managerial change within many of our countries' health-care systems. Health care has been commodified to the point whereby our relationships with the people who come to us for care have been twisted into the most morally bereft of economic exchanges. Our language of care and concern, the subtlety of the knowledge and skill embedded in the best of our practices, the unpredictability and uncontrollability of the most inspired and creative caring are unrecognized and unrewarded in a system that finds them to be a cultural and professional embarrassment. This is because they stubbornly resist attempts to force them under the contemporary template of measurable outcomes, prescribed standards, mission statements, mandated competencies, effectiveness and efficiency, and cost containment.

We face the real danger that nursing may soon be viewed as being little more than just another corporate, slick, customer-pleasing strategy, to be prescribed and ordered. This should be our worst nightmare: the 'McDonaldization' of nursing.[8]

Educators and researchers have also witnessed the mutation, through this same enframing understanding, of the idea of the university as being a place of scholarly dialogue and a nurturer of wisdom. Knowledge and learning are rapidly becoming as commodified and ordered as health care. The behavioural pedagogy that Nancy Diekelmann has so carefully critiqued[9,10,11,12] and the philosophy that bore it are alive and well although their terms may have changed.

The panoply of learning outcomes, transferable skills, prescribed competencies and so on exemplifies the same modernist project of rationalism and the worship of predictability and control. In our new 'degree factories', the same desire exists for uniformity of 'product': formation and creation of a homogeneous collection of competencies and the necessary 'adaptability' (for 'adaptability' read 'compliance'); in short, production of the nurse who will blend seamlessly and interchangeably into the current market-driven world of health-care provision.

Research and scholarship are no longer considered mainly in terms of knowledge development and enrichment of practice but of how much money and kudos they will earn the institution in the next research-assessment exercise. Our lives with students become more mechanized and impersonal as their numbers rise and also as their understanding of education becomes an economic and instrumental one: 'I've paid my fees and attended the classes and I'm therefore *entitled* to my piece of paper with "Degree" printed on it so I can please my employers.' Less reputable educational institutions will happily collude with this slide or, as they might put it, 'provide more flexible educational opportunities in order to satisfy the demands of our consumers.' More apt perhaps is Benner's cautionary description of the provision of mere 'stamp-me-smart courses'.[13]

Nurses are well aware of the effectiveness-and-efficiency treadmill they walk and that militates against thinking and dialogue that is more meditative, contemplative and reflective or whereby no specified instrumental ends are being served. In his landmark book *Zen and the Art of Motorcycle Maintenance*, Robert Pirsig painted a sad picture

of this educational treadmill. As you read the following quotation, substitute 'nurse' for 'teach' and 'hospital'/'unit' for 'school'/'college' in order to provide an insight into the current practice of many clinical nurses.

> *The school was what could euphemistically be called a 'teaching college'. At a teaching college you teach and you teach and you teach with no time for research, no time for contemplation, no time for participation in outside affairs. Just teach and teach and teach until your mind grows dull and your creativity vanishes and you become an automaton saying the same dull things over and over to endless waves of innocent students who cannot understand why you are so dull, lose respect and fan this disrespect out into the community. The reason you teach and you teach and you teach is that this is a very clever way of running a college on the cheap while giving a false appearance of genuine education.*[14]

Nancy Dickelmann writes of teaching as being the practices of welcoming and gathering, the gathering of colleagues and the welcoming of our voices and ideas. We know all too well the reasons why some of our communities in nursing are so poisonous and destructive. Yet we also know how we can create communities of practice, education and scholarship that are characterized by fairness and mutual respect. Could it really be as simple as thinking about how we listen and speak? In a true community there is respect and fairness. We can listen and discuss even though we may not share a similar perspective.

If a postmodern sensibility can do anything for us, it should be able to help us see through and overcome the destructiveness of our dichotomies. Can we construct our clinical practice and scholarship in a way that enables us to attend to more elemental concerns than practice versus theory, ideal versus real, qualitative versus quantitative, and the other binary divides that preoccupy us? Can we also engage in a critique of the radical individualism that shapes so much of our current understanding and practices? The cult of the primacy of the individual and individual autonomy has a dark side that pushes us towards 'atomism', fragmentation, competitiveness and isolation and away from an understanding and a conduct that are more connected and relational.

A ward leader–charge nurse spoke to me at a London conference about a colleague whose practices and attitudes were causing her concern. The ward leader said it was difficult for her to raise these concerns or be in any way critical of her colleague because, as she believed, 'she [her colleague] is an autonomous practitioner and thus responsible for her own practice.' Peggy Chinn is surely correct when she warns that in a hierarchical system of health care, the emphasis on individuality mainly serves to divide us from each other, thereby becoming a powerful tool for sustaining oppressive and self-centred relationships.[15]

PREDICTIONS ABOUT FUTURE TECHNOLOGY AND PRACTICES

No one can see into the future, but some things do seem reasonably predictable. Technology will continue to develop at a rate that will both amaze and terrify us. It will not stop, but it will need critical and informed voices to question its hidden assumptions, underlying values and more extravagant claims. Will nurses be able to do this? Nurses' most creative and courageous caring practices will also be needed in order to humanize its potential excesses and inevitable practical implications.

Communicative patterns and technologies will advance incrementally. Internet gurus tell us we are no more than three people away from the president of the United States. Are we ready for the day when patients have ready-access laptops that have records, CD-ROMs full of medical information and, perhaps, connections to other patients across the world, or will our power structures and vested interests ensure that this knowledge and power remains with the professionals? Or is the electronic revolution just another plaything of the rich? Is the 21st century to be divided not only along the faultlines of rich and poor, hungry and fed but along the new faultline of the people who are 'connected and informed' and the people who are not?

Somehow, however, cyberspace seems to be the least of our worries at a time when, for example, Deborah Tannen's work shows that men and women are scarcely capable of real mutual understanding in their everyday conversations[16] and when Croats and Serbs, or Hutus and Tutsis, can have nothing to say to each other but instead speak with bullets and machetes.

All health-care systems face a scarcity of resources, and the press to turn health care into simply another business seems unstoppable. However, just as water will eventually find its way through or around any obstacle placed in its path, nurses will continue to strengthen and modify their caring practices in order to protect patients from the worst ravages of cost-containment measures. I would maintain that patients, and the people who come to us for help, understand the elemental difference between being

a customer and being ill or injured or vulnerable in hospital. People do not want a 'customer-services representative'; they want caring nurses. They want to be cared for and about by someone who is not merely going through the motions or 'operationalizing the unit's Total Quality Management strategy in order to maximize the effective throughput of unit costs in order to guarantee total customer satisfaction.'

This was made memorable for me during the interviews I undertook as part of my doctoral study.[17] These were guided conversations with parents who lived-in with their child in hospital. At one point I asked parents to tell me about particular nurses or nursing actions they had especially valued. Parents spoke of the importance of feeling and being cared for, of feeling included and involved, of feeling they actually mattered to someone. These parents' accounts are valuable examples of the kinds of 'connecting conversations' that can transform parents' and patients' experiences for the better. Two examples of the conversations are as follows.

> Mother: *The relationship changed from them doing a job and me just being there basically. It wasn't really a relationship. They were just the nurse and I was the patient's mother ... and they were always friendly, but they were just doing their job. They were just being friendly to you because you were in distress, whereas now I feel they are more friends ... You know they all do care so much, it's grand, it really is ... because it is a relationship now.*
>
> Father: *A lot of the nurses ... we've been in so long now, it's as if they're just pals, know what I mean.*
>
> Mother: *A special relationship.*
>
> Father: *Yes, it's not a nurse ... a nurse–patient or a nurse–parent you know. It seems to develop into* us, *I mean you can talk as if it's someone you've known for ages.*[17]

This paper's introduction claimed that nursing was in both the best and the worst of times. If the juggernaut of modernity, with its press to colonize our every response and instrumentalize every aspect of being and world is the worst of times, the best is our ability to resist the press.

SUGGESTED STRATEGIES FOR OVERCOMING THE OBSTACLES

What kinds of connecting conversations and practices can nurture and support alternative approaches to scholarship and clinical practice in today's climate? Our current understandings can be resisted only by showing they are simply not inevitable and are only an interpretation (albeit a very powerfully backed one) of the way things are and should be. Interpretative, narrative, feminist and other critical approaches to education, practice and research open new possibilities for nursing by challenging us to think anew about everything we may once have considered to be unproblematic or given. However, note that these are alternatives, not the new orthodoxy. This does not mean our colleagues who teach clinical skills and procedures, or physiological researchers who use surveys or experiments, now have to be demonized as the positivist enemy. Paradigm wars do not make for good connecting conversation.

This can be illustrated by citing two examples, from my own practice as an educator, approaches that have opened up fruitful connecting conversations between scholarship and clinical practice.

Example 1

My first example is as follows. For the past three years, my colleague Janice McCall and I have been teaching the UK's first accredited course on understanding caring through arts and humanities, whereby we seek to create new understandings of caring and human experience through the study of literature and arts. During the course, we dialogue and explore nursing, caring and the experiences of illness, health, dying, disability and the nature of interpretation. We have explored the power of humanities, combined with an interpretative pedagogy, to gather around us particular texts and other arts, thereby opening up possibilities that traditional educational approaches cannot open up.[18–21] Focus-group hermeneutic evaluations of our students' experiences have been almost unfailingly enthusiastic and positive about the quality of the communities of learning we created and about how the experience of the course positively affected students' learning and clinical practice.[18,21]

Example 2

My second example is a personal story. I teach a course for undergraduate nursing students who qualify as registered nurses for people who have learning or developmental disabilities. The students' first sustained period of practice experience is spent on a 'family placement' as a 'guest' of a family that has a child who has special needs. During the placement, the students and I attended a day

conference on the theme of creating partnerships between parents and professionals in relation to special-needs services. At a workshop, one parent plucked up all her courage to suggest, as diplomatically as possible, that only occasionally parents do not have positive experiences of professionals and their services. The reaction of each of the various multidisciplinary professionals who were present was to go around the table, announcing that of course *they* do not do that in *their* practice or place of work. This ritual personalization of the mildest of criticism continued, with no one seeming to appreciate how disempowering and oppressive this show of professional force was for the parent involved. Eventually, it was a nursing student who noted that none of the assembled professionals seemed to be able to say to the parent, 'That's really interesting that parents feel this way; can you tell us a bit more about it?' I held my breath and let the wonder in. Someone, and perhaps significantly, a student nurse, had recognized the discourse of domination and had understood how to create and how *not* to create a connecting conversation.

RE-EXAMINING 'REALITY'

The examples I have cited are small, but when you add them to your own, and to those of your colleagues, and to those of other nurses throughout the world, you see why these can also be the best of times for our scholarship and practice. Heidegger has highlighted the power of the smallest and seemingly most insignificant of our practices. In his essay 'The Question Concerning Technology', he observed, 'Where danger is, grows the saving power also ... Here and now and in little things, we may foster the saving power in its increase'.[22] Underpinning each saving practice and seemingly localized and small-scale imaginative project is a profoundly subversive understanding that this thing called 'reality', which the people who are in power urge us to face up to and acquiesce to, is in fact socially, politically and philosophically shaped and constructed. And as such, it can be socially, politically and philosophically deconstructed and reconstructed.

CONCLUSION

Nurses are rightly concerned about the future of nursing and the possibilities for new and better futures, but as Martin Luther King, Jnr said in his immortal 'I have a dream' connecting conversation, 'We need to remind ourselves of the fierce urgency of *now*,' (reprinted in[23]). The past is the basis of our present. Our present is all we have, and our future exists only as possibilities. However, we are not working *towards* some new future; we *are* that new future, right now. John Lennon once said that life is what happens to you while you are planning your future. We *are* this new future every time we teach a class differently; every time we think differently about a problem or issue; every time we agree and disagree respectfully with colleagues; every time we ask ourselves, in our own research, the question 'So what?'; every time we ask of our clinical practices, 'Why are we doing this, and why are we doing it this way?'; every time we ask of our wards or units, 'Would I be absolutely happy for my parent or partner or child to be cared for here?'; every time we allow ourselves to think what, yesterday, may have been the unthinkable. As Nancy Diekelmann has argued, true revolution may be as close or as distant as a change in thinking.[12]

I cannot predict the future, but I *do* know exactly when the revolution in our thinking, our conversations and our practice will happen: when each of us lives and works as if it had already taken place.

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