

PONT DU GARD FORUM

“Let’s Get Real”

Turning a Blind Eye or Seeing Truth

Ferguson-Paré, M.
Mitchell, G. J.

The Healing Waters of Pont du Gard

There is an architectural wonder in the south of France called the Pont du Gard. This structure completed in 19 BC consists of arches that support and channel water over many miles to the city of Nimes. The structure has provided for communities of people who required and shared refreshment and nourishment from the flowing water. Like the life-giving water, the vision for the initiative described here is to create a channel of dialogue, understanding, change, and growth. A dialogue that offers nourishment for nurses, just like the Pont du Gard offered nourishment for thousands of people in the south of France.

The Pont du Gard inspired nurse leaders from two large university centers to think about the possibility of creating a place where nurses could gather to explore and discuss the tough issues and hard questions about nursing and the workplace. A place where nurses might feel free to question and to seek answers about things they always wanted to ask but were afraid to voice—things about ourselves, our work, our colleagues, our leaders, our intentions, our failures, our shames, our hopes, and our fears. A place where truths are invited and respected. A place for nurses to consider the meaning of community among nurses who believe in compassion and knowledge. A place for nurses to ponder and discuss questions such as: How can nurses stand tall and cherish the reality that they make an incredible difference to the client’s quality of life? How do organizations support and honour the work of nurses and their intent to care for persons and families? How do nursing leaders enhance the voice of front line staff nurses? What silences nurses? And, how can nurses and nurse leaders stay true to their values?

This column presents a dialogue among nurse leaders and others who participated in discussions about nursing and human care. The hope of the authors is to enhance understanding about the knowledge, processes, and structures that impact nursing worklife and that help and hinder nurses in their work to create compassionate relationships

that enhance health and quality of life. The dialogues represent opportunities to seek the truths that will help us understand the realities of nursing—in large organizations and perhaps beyond. We believe that understanding can lead to changes that may restore and enhance human care and compassionate relationships among all nurses who share in the life-enhancing dialogues presented in the columns.

Gail—The nurse’s comment about wanting to have a life in addition to being a nurse was quite striking in today’s Pont du Gard discussion. You have to wonder how nurses are being helped to prepare for the reality of working shifts as well as the intensity of the work they will encounter, especially in hospital settings.

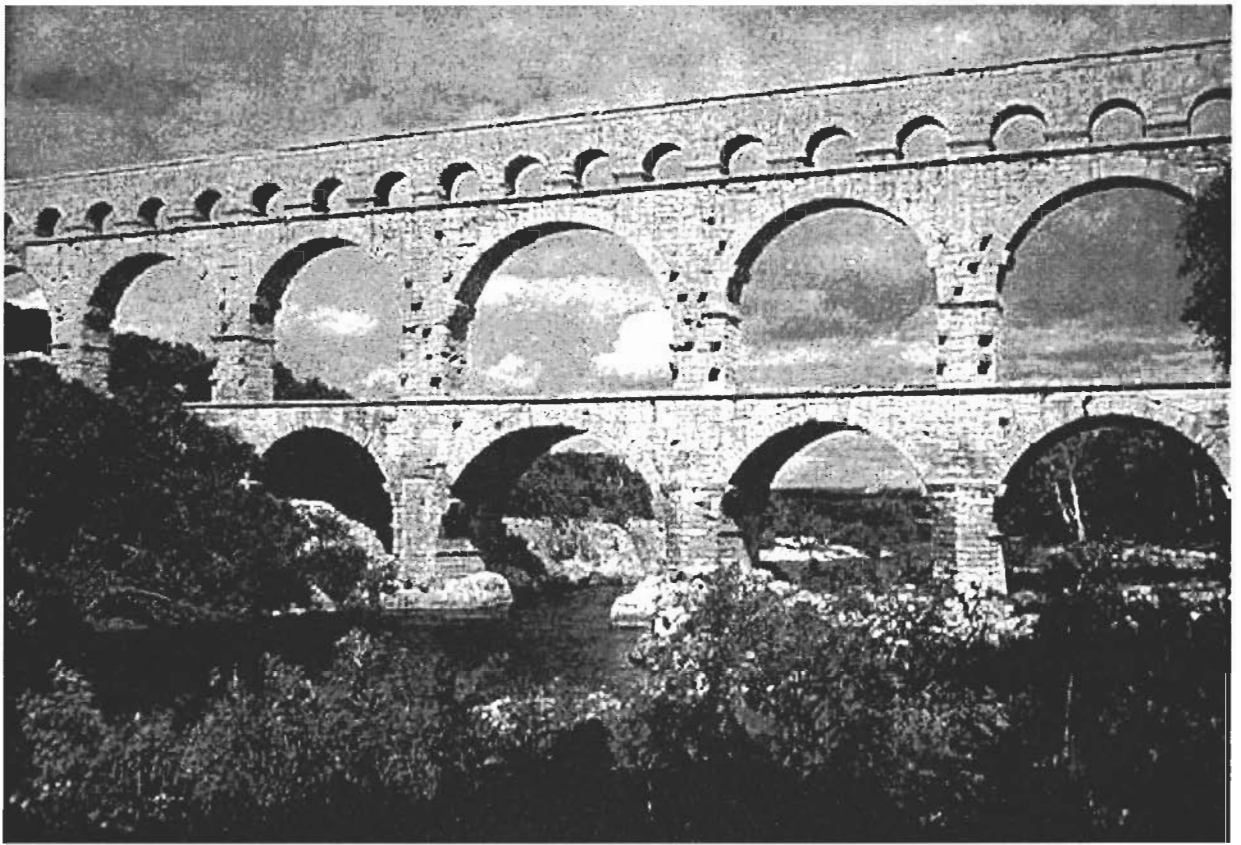
Mary—What was intriguing was the discussion about sacrifice and that some nurses are not getting the support within the organization that makes the sacrifice worthwhile. Is this about respect or should I say the lack of respect that always seems to surface as an issue of concern for many nurses?

Gail—I think some nurses attending this session were saying they did not feel respected and valued enough—yes. Being expected to work 12 hours a night and not have access to food was a telling example of how disrespect is conveyed.

Mary—Yes, and the nurse who spoke about how she felt totally unsupported when her colleague died on her unit. No grief was acknowledged; it was just another day—get back to work. Another expression of disrespect for nurses and their realities..

Gail—Interesting that the nurses compared the support they were offered when a colleague died with examples of what students’ experiences when a classmate dies. Nurses questioned why teams of psychologists are asked to help students who experience grief but no one is asked to help nurses when they lose a friend or colleague. Are nurses’ experiences of loss less serious or less intense? How do managers and leaders help nurses and what messages accompany our offers or denials of support?

Mary—Well according to some nurses we give messages that do not encourage disclosure or discussion of their realities. A few nurses said they do not feel valued in their work and the work is, as we know, incredibly challenging. They spoke about being left out of the mainstream of hospital life when working shifts. Meetings, celebrations, and ceremonies all happen during the day shift. Managers and advanced practice nurses work day shift. Education happens on day shift. Patients have more access to services on day shift.



Gail—The discomfort over what happens to some patients was also quite telling. At least some nurses believe that patients are not allowed to die and that medical treatments sometimes occur to benefit others' interests. There was a kind of realization that what happens to people in hospital is not always aligned with what nurses thought they would be doing with people.

Mary—Yes, the old cure/care issue. But the nurses sounded so powerless. They see a reality that is uncomfortable and pretty much unacknowledged, or certainly not openly discussed. The focus on economics and efficiencies is taking a toll that may not be visible or obvious.

Gail—It is a concern because we know that nurses find meaning and satisfaction through their relationships with patients and families. Reward for relationships with patients helps nurses to be with the disregard that also happens in our organizations. Actually, when the nurses were talking about disregard for their realities I was thinking about Cody's (2001) study that defined mendacity as the refusal to bear witness. What a profound concept for thinking about nursing practice and nursing experiences. What is the extent of mendacity in healthcare organizations? What are the realities that we turn away from?

Mary—We expect nurses, to bear witness to patient's experiences. What will happen if nurses turn away from the realities that patients and families experience? And yet we do not honor or bear witness to the nurses' realities. The organizations we have created are full of mendacity and also full of truth, depending on whose reality is being considered.

Gail—I am afraid that it may become easier to turn away from painful realities as organizations continue to experience financial pressures. Research and the enterprise of science may also place demands on nurses and patients to turn a blind eye to difficult realities. I worry about practice becoming ghettoized which may further drive nurses away from direct care of people.

Mary—Nurses have got to be there for patients. Although the 24/7 coverage is difficult and requires sacrifice, the reality is that patients need nurses there to be there in the system giving voice to their concerns and and to representing their interests in our very complex organizations. There are now multiple and sometimes competing values and agendas among healthcare professionals. If nurses are not there for patients, quality will become an even bigger issue.

Gail—Absolutely. I was thinking about the notion of strategic withdrawal that Ceci and McIntyre (2001) described. These authors suggested that there is a quiet crisis happening that has to do with a foundational disregard for the work of nursing. The notion proposed was that the nursing shortage is not simply one of numbers—there is a deeper, more unsettling truth buried there.

Mary—And wasn't it interesting when the managers also acknowledged their frustration with not being able to help nurses in ways they wanted to. The reality that there are not enough supports and that nurses have to spend a lot of time running errands or trying to get the necessary supplies and equipment to care for the patients. This is quite different from the days when nurses would have everything ready for the doctor to do a procedure and the nurse would provide assistance too.

Gail—Yes. The message in the readiness we provided was that doctor's work was important enough to worry about and support so they could give patient care. Our systems do not give the same message to nurses. Is it any wonder then that nurses do not feel valued?

Mary—Interesting that some nurses in the group believed that the only thing that nurses can really control is the quality of their relationship with patients. But the reality is that workload does impact on the opportunities to create those relationships and it is workload that most concerns nurses. Workload and support, especially support from managers, is critical for nurses. Support that is caring and compassionate, comforting and considerate of the nurse's reality, as essential for staff as for patients.

Gail—Seems a fitting time to end this discussion. We have engaged the mendacity of systems and the power of relationships and genuine regard. Now the choice facing many nurses as we go forward is to turn a blind eye or see and speak the truth of the moment.

Authors

Dr. Mary Ferguson-Paré is the Vice-President and Chief Nursing Officer at University Health Network, Toronto, ON. mary.ferguson-pare@uhn.on.ca

Dr. Gail J. Mitchell is the Chief Nursing Officer at Sunnybrook & Women's College Health Sciences Centre, Toronto, ON. gail.mitchell@swchsc.on.ca

Your comments are appreciated. Please email the authors.

References

Cody, W. K. (2001). "Mendacity" as the refusal to bear witness: A human becoming hermeneutic study of a theme from Tennessee Williams' "Cat on a Hot Tin Roof." In R. R. Parse, *Qualitative inquiry: The path of sciencing* (pp. 205-219). Sudbury, MA: Jones and Bartlett.

Ceci, C., & McIntyre, M. (2001). A 'quiet' crisis in health care: Developing our capacity to hear. *Nursing Philosophy, 2*, 122-130.