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Event
2018 NCSBN Annual Institute of Regulatory Excellence (IRE) Conference

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- [Nelda] So, it's a pleasure to be with you. I am hoping that my hour and a half just zips by, that you think, "Oh my gosh, that really couldn't have been an hour and a half." So, that's my main point in starting this. I am introducing this idea to a number of you, knowing that you've thought about it in the abstract sense, but when I'm bringing up the term professional identity or professional identity formation, this is not necessarily part of our normal language in Nursing.

And by putting an emphasis on it that has to do with interprofessional, I hope I'm creating a compelling case for what is going on all around us with our other health professions, and where Nursing needs to be, and what things we need to do to help that happen. So, in my past life, I've been at the University of Kansas now for 10 years, Research Intensive Tier 1 university.

But before that, I spent more than 2 decades teaching in a top 100 liberal arts college, which meant that I had the great good fortune of teaching for 15 years in the Liberal Studies curriculum, not the Nursing Liberal Studies curriculum but the Liberal Studies curriculum. So, I've been able to teach the Bhagavad Gita, the Hindu scriptural texts, the St.

Augustine's Confessions, E.O. Wilson's Consilience, teach a class called Money, Medicine, and Morals to students in 20 different disciplines. And so, you're going to hear the philosopher come out today as we talk about this, and I think that I bring it up because I think it's a good lens by which to look through how we are, in Nursing, as our very old profession but our very young academic discipline.

So just to kind of kick this off, if you could imagine, you know, that in the 12th or 13th century was the first time that there was a terminal degree in education, that was in philosophy or theology. And in at least my lifetime, I remember people talking about Nursing being a semi-profession.

That's Tim Porter-O'Grady's, not claim but work, he had used that terminology. So, you have partners at your table, look around, see who's somebody that will talk with you. Can you look around and see who

will talk with you. Yeah, okay. Good. Good. All right.

So, here's my question. So if the first PhD in Philosophy and Theology was in the 12th or 13th century, when was the first terminal academic degree in Nursing? When was the first PhD in Nursing? Go. If it follows that we have, at least in the last 40 years, been claimed in some writing as a semi-profession, you could think it's not been all that long.

So the very first PhD in Nursing, for all intents and purposes, was in 1970. Now, there are people in this room who have a memory of 1970, aren't there? Yeah. And for those of you who do not have a memory of 1970, if you remember watching Apollo 13, and so there's that really poofy hair and those really short dresses, that was 1970.

So, it seems actually like a long time ago when we think about it that way, but just for a moment, think how far we have come as a discipline. We now have over 100 schools that are granting PhD degrees in this country.

We have 223, at last count, that are doing the professional doctorate. So, we have come a very long way in a very short period of time with our academic discipline. So, I've put the objectives up there for us and you've got them in your handout. But what I want to think about, first, is why would we be talking about professional identity, not just the term, not just the language, but why is it important that we look at it?

Well, the first objective I have listed is the importance of teamwork with professional identity. And if you have not read this, there was a Harvard Business Review article. It's in your reference list down here, Harvard Business Review article done in 2013, which sounds like a long time ago, by Porter and Lee.

Lee is one of the leaders in the Partners Program in Boston. This was a very clear picture of what these gentlemen, who are visionaries in healthcare, thought was going to be the way we're going to fix our healthcare system.

This is what value-based care was going to look like. And so, I'm just going to read through...not all of them, but how is it that this could actually happen? One, we have to be organized into integrated practice units. Two, we have to measure the outcomes and cost for every patient. Three, we have to move to bundled payments for care cycles.

Four, integrate care delivery across separate facilities. Five, expand excellent services across geography. Six, build an enabling information technology platform that is going to require a tremendous amount of synchronicity, isn't it? That cannot be done with a medieval hierarchy. It really can't be done that way or any other kind of hierarchy.

It's going to have to look really different. In our world, we talk a lot about patient outcomes. There's even some conversation in the health professions about finding ways for us to look at how we teach a student and that carrying through to how they care for patients. I think that's a pretty tall order, myself, but maybe we'll be able to get to that.

But our language is filled, our time is consumed with outcomes like we have measured them to this point, but I would argue we need to look at terms a little differently. So, let me define some terms for you.

The first one is professionalism, and I have a story about that. If you are thinking professionalism and professional identity are fairly closely aligned, I think you would be correct. However, what we have found, my colleague and I wrote this book called The Making of Nurse Professionals: A Transformational, Ethical Approach, and what it does, it's the philosophic inquiry into the term professionalism.

Well, if we lined up 100 people or 100 nurses around the room, we would find that people had different definitions of what professionalism meant and that's the flaw because you can have a professional carpet cleaner. But to think about what professionalism is in a profession, it's a very tough nut.

So, is there a way we can find another way to say that? So, I'm going to be talking a fair amount about...from an interprofessional standpoint, mostly about medicine because it is our colleagues in medicine that have done an amazing amount of work in this area fairly recently.

So, to my colleagues from Canada, I tell you the story of doctors, Richard and Sylvia Cruess. These are faculty at McGill University in Montreal. They both practiced as surgeons until age 65 when they retired from being surgeons and they are now 85.

And for the last 20 years, they have been wrestling and working with this idea of what is professionalism in medicine? What does it look like? How can we measure it? How can we teach it? How can we get there? And about the time they first started looking at this, the standard in medicine was this, "We know we need to teach..."

medical education, "We know we need to teach professionalism, so let's test it.Let's measure professionalism." So they would create surveys and measure professionalism, they would teach professionalism without a particular curriculum grounded in a theory base. And a number of you are doing research and you know about the necessity of including a theoretical framework before you start all this, but they just jumped right in, and said, "We're just going to start assessing professionalism."

And Cruess and Cruess about seven or eight years into that said, "Wait a minute, this is not going to yield us the results that we need. We don't have enough of a foundation for this." And I'll be talking a little bit more about what that means and how other authors have come in and helped work with that, but they have come up with the idea about identity formation or professional identity.

And then, since most of what I have for medicine is from medical education, its been in nursing that we've been talking about forming and fostering. So, if you're thinking about how we influence students and how we influence practicing nurses, forming is the front end and fostering is post that first educational experience and going forward.

So, I would argue that we can define professional identity as this, "Professional identity and nursing is a sense of oneself that is influenced by characteristics, norms, and values of the nursing discipline resulting in an individual thinking, acting, and feeling like a nurse."

Now, Dr. Crigger, my co-author and I, used the core of what doctors Cruess had come up with at McGill because this is...after their 20 years of thinking about this, this is where they have landed. So you would see their definition of professional identity and medicine being, thinking, acting, and feeling like a physician.

So, that person you talked to just while ago, I'd like to see if we could informally chew on this a little bit and see whether this has any meaning to you as we're talking about professionalism and then the next iteration, professional identity. I'll give you about 60, 90 seconds to do that.

Thank you. And bring up a bit of a foil to this. Some of you are involved in practice, some of you are involved in education, and I'm sure, at one time or another, you have been frustrated with inadequate measurement tools. I am sure that each of you could argue that perhaps patient satisfaction is not the best indicator of what kind of care people receive in the hospital, right?

I mean, it seems limp at best. I'm being kind in my language, but can you imagine if that was your daily or an age gaps too, to have to get a 9 or a 10 to make it count. I mean, in some ways, our measurement's at least not there yet. So, put that against a definition that came largely from 2 surgeons who are 85 years old, who worked actively in surgery all those years, this is pretty touchy-feely, isn't it?

And what they have concluded is that this is a better description of what we're trying to get to. And I've spoken with them on the phone and even more what they talked about is how the lines are much more blurred than they ever understood, and they are trying so hard to have a healthcare professional model rather than, "This is what a physician does.

This is what a nurse does," really trying to look at this much more together. So, hopefully, we will get to that and medicine is helping us do that. But can you imagine, in the medical education world, how transformative they have been by using this kind of a definition and then creating curricula and measurement instruments that came off of something like this?

It's quite a move. So, in terms of identity formation, what do we know from the literature? We know that it is an implicit or explicit part of all professional education. And what we're seeing in the research literature too is that we must, intentionally, address this.

You know, if you don't have something up front, you don't end up doing it. We all know about focus. Sometimes if you don't have things on the list, they don't get done. If you don't have a focus on this, this doesn't get done. I have been in practice up until 10 years ago, working med surg on floors on the weekends on a part-time basis.

But the last 10 years, I've been at this academic health center and we had a major curriculum revision, so I'll tell you our story. We've been around for 106 years at the University of Kansas and we were pretty sure we're pretty hotshot nursing program, you know how that goes. And we started looking at how the criteria for measuring our disciplines, called the AACN baccalaureate essentials outcomes.

So we started looking at that. And when we saw that the analysis said that about 25% of what we needed to spend our time on was professional identity and communication, and those of you in practice would

not disagree with that, how important professional identity and communication is, we found that out of our 64 credit hours, we had one credit hour on informatics.

And we had made the promise to ourselves that we were going to proportional eyes our curriculum based on the analysis, and we have. And we now have 7 credits out of 64 devoted to 3 courses in professional identity formation. We know it has made a substantial difference in the students being grounded in what they're there for.

They have some idea why they are there. So we could talk more about that but we probably won't at this point. So, let's use an example of forming and fostering, and one of the reasons I bring this up is, at our school, our nursing advisor for beginning nursing students says that, still, her biggest problem is professionalism. "Nelda, we still have problem with professionalism with our students."

So, what does that mean? Well, of course, we have a wide generation span that we're working with. There are certainly cultural divides in how different groups communicate with each other. We know that. But I thought maybe this would be an example of maybe one situation in practice where we have some professional identity work to do.

I'll read it. "Nurse K. is the next professional nurse to care for Mr. R. Nurse K. is taking courses for graduate school and has a family of younger aged children for whom she is responsible. She views work as a necessary evil, "Without work, I don't support my family." Let's see, here is my list of tasks, may as well start with Mr.

R. Hurry, hurry, here's the care plan. If I work hard to do all the duties, then I can be done by 9:30. I can break then and call Michael's school. I also need to get online and email the cable company. Lunch, I may have some time to run to the store and back. Laura can probably cover for me.

So rather than me discussing this with you from the podium, why don't you, again, talk to your colleagues about professional identity formation deficits that might appear. There are several, might appear in here. So, please, talk. We have wise, wise people at these tables. I think it would be a really good thing...this generated a lot of interest, I can't tell.

So, let's think in a more positive vein with this. By the way, this is a real story. I bet you knew that, didn't you? I mean, don't you know this? This is how some stories go. You are nurse leaders, every one of you.

So what would you do if you were going to coach this person? What would you do? Where would you start? What would be the thing you would talk about? And so, I actually would like for you to do that, again, at your table. Think through two or three approaches or steps you might take in coaching someone like this. I mean, you have to assume that you're not just walking in off the street.

I mean, you have some legitimate reason for someone asking you maybe to talk to her or something, what would you do in terms of coaching? And then I'll ask several of the tables to report out on your ideas. Okay. All right, I'd like to ask for four of our tables to report out, four, maybe five. So if you think you're a candidate for that, why don't you just go to a microphone and we'll let you tell us what your plan was because I think we'd like to hear what your approaches might be.

And we'll be listening for themes, we'll be listening for facets but also for themes. So, okay. Great. Thank you. - [Ruby] Hi, I'm Ruby from Oregon and this is my table over here.

And I can tell you that I've actually had these nurses. I actually was one, single parent, responsible for kids, but what I used to tell my nurses once I adopted the professional identity was that, "If all you did was tasks, I could save our hospital a lot of money, be a hero, fire all of you and hire technicians."

But for this particular person, again, having been in this position, it starts with, "Tell me what Nursing is,"and based on her answer, that's when you take her through because I don't think there's a pathway to do this without understanding her motivation and her needs because you can't get away from being a single parent with young kids.

Those things are not going to stop, no matter if you think you're a professional or not, but it all depends on, when you ask the question, "What is Nursing and why there are nurses?What is the point?" Then based on her answers, just move along because, I guess, I don't think there's one way to handle this situation.

- Okay, very good. Thank you. Someone else? - [Woman 1] I think one thing that's missing in this is the joy of nursing. I think this nurse feels very frustrated and has kind of a to-do list that means to an end.

And I think just kind of working with her and saying, you know, "How can we bring the joy back into this 8 hours or 12 hours and really kind of getting back to the bones of it?" I think would kind of bring team, you know, if she's overloaded, well, let's get a team to kind of, you know, get together and take on some of the extra burden. So, there's actually that team approach and making work fun.

- That's great point. That's a great point. - [Woman 2] So, Nelda, as a former regulator, I think I shouldn't speak for everyone in the room. We hear, "This is a typical story." And, you know, I think that, while she maybe does need to rethink professionalism and what brought her to this career and profession, as a nursing leader on that unit, she needs to rethink, "What is happening on my unit that this nurse doesn't have time to make a phone call, doesn't apparently have time to probably take lunch? I mean, how do we restructure the profession and what goes on so we prevent her from making a serious error?"

And, you know, I think that sometimes we blame the nurse but what, also, not we, as regulators, can't step in and tell them to change their unit but the nursing leaders on those units and the administrators should be thinking, "How do we make our staff more capable of living a life, being professionals, and preventing them from making mistakes?"

Because if she makes a medication error and comes to the nursing board, you can give her all the medication courses and everything else in the world, but until you get to the bottom of what these problems are and how she can manage them better, you won't prevent her from making a mistake.

- So very true. Now, every one of our states and provinces has rural areas to it, so you should not be surprised if I tell you she drives 1 hour in to do a 12-hour shift and 1 hour home, and you know nurses who do this and more.

Some are doing an hour and a half drive in, and that's their life. That's their life. Couple of others, any other comments for this? - [Man 1] So just a couple of thoughts, I want to add a little bit of what Ruby was talking about and I completely agree, none of this goes away, right? So this is the new reality.

And what I think is really important to continue to come back to, especially in this scenario, is to stop objectifying the patient as a means to the end. I was telling my colleagues that, "I think the way that I would approach Nurse K in this scenario is to sit down with Nurse K and ask her to tell me Mr. R's story," and try to tap into the limbic system, right?

Tap into the emotional connection because somewhere in there, in the middle of all this busy, and all this hurry, and all of the very complex things that the nurse has to do, and I agree, we do have to figure out how to restructure what they're doing. They're spending so much time on the computers and the EMRs documenting, they're not spending enough time to learn Mr. R's story. But tapping into that and helping her see again that Mr.

R is a person, is a father, is a husband, was somebody's son and has a story, because that's really the connection that the nurse makes more than any other discipline, in my opinion, because we are there at Mr. R's most intimate time of need. That's a privilege to be able to provide that type of care to Mr.

R. So that's, I think, where I would go with Nurse K, to try to connect her to refocus and reset to her on the moment rather than all the other stuff that's going on.

- And it's our honor to serve as well. So if we can create that sense, again, that goes... Any other group want to speak up? I saw some points but maybe not, okay. Well, I would argue that one of the things that we can do in this, in addition to the things you've talked about, is that we can enlarge our language.

And I think this comes from being a young academic discipline, that we don't always have as many words maybe as we will have as our discipline matures. So, I have a piece of research data for you. I would argue that perhaps it's not just enlarging our language with positive things but maybe we need to look at our language in general and take a critical look.

So here's my story. I did a search in CINAHL for the last 5 years on the term incivility and I did it on research articles. I clicked the research box and I found 105 research of articles that had the term incivility. I looked in PubMed, under medicine, I found 14. In physical therapy, one.

In occupational therapy, zero. Respiratory therapy, zero. Social work, zero. What is this saying about us? What does this say? So you must talk about that. I won't have time to dialogue.

Talk at your tables about that, what does that say about us? Now, I'm going to jump in earlier on this one and rescue you from this negative comment because this isn't the prettiest thing to talk about. And from an academic standpoint, I'm not sure we should tell people what they can and cannot do research on.

I mean, really, I'm not sure we should do that either but I will tell you that because of that information and because of a small cadre of us who work in this area of incivility in nursing, and professional identity in nursing, that we really are talking now about enlarging the conversation, moving from a

symptom, incivility, to a structure thinking up to think about what professional identity could actually be.

You might not know this, but Shakespeare added 1,700 words to the English language, and in fact, his vocabulary was 24,000 words which is more than Homer, more than Milton. So he really...I've heard it in country terms said that Shakespeare increase the number of words in the English language half again as much.

Does that sound like a country term to you? Half again as much, many words we have in there. And just as a funny thing, I just thought I'd let you know what some of those words are that he invented: compromise, epileptic, equivocal, elbow, gossip, I have a whole list. So, anyway, just kind of an interesting thought but it's probably an okay thing to be thinking about in our young academic discipline, we probably are going to need to think about better language, maybe more full textured language.

So, my colleague, Nancy Crigger and I, proposed this to you that on...my license, I believe, in Kansas says, "Professional registered nurse." So if we've been substitute that and say, "Professional registered nurse," for my license means that I'm validated by examination in Kansas or in some countries by institutional verification.

But what if we started using the term nurse professional and we had language that hung with it and looked like this? A nurse professional is a person who professes to be a member of a discipline, the discipline, and has individual qualities or characteristics that inform and motivate him to make good moral choices.

You remember Dan Patchett's [SP] presentation yesterday, and what did he say? He said, in his thinking about this, he thinks it's going to be more about values. It's probably not only going to be about values but it's going to be more about values.

What do my colleagues, the surgeons, think? That it's more about thinking, feeling, and acting like a health professional. Thinking, feeling, acting like a nurse. So the challenge, a challenge in this is, okay, how do you get this to convert to things that we do, that we value, that we measure?

How do we get that to actually happen? Because, I think, in many cases, we tend to reduce things. There's a term in philosophy called reductionism, where you just reduce something to an understanding that is way too small to encompass it. So, in the healthcare terms, is it really all about outcomes? Is it really all about outcomes?

Is it really all about outcomes? I'm not so sure. Is it all about the money? Now, you know, I think, I hear, "Is it all about the Benjamins?" more and more, more than I used to. I mean, what happened in January with bundled payments for healthcare? Fifty-percent of the major diseases were started to be put into bundles by CMS and, you know, CMS is pretty indicative of what happens for us.

So, is it all about the money or is it not? And then that age-old question, why do people do what they do? But that's a lot longer conversation than what we'll get into today. So I want to introduce you to what part of the conversation that's happening in medicine because I think they are a good place to go in thinking about this.

And interestingly enough, I got to tell you, it's just a small group of people in medical education that are moving this forward. This isn't all the members of AMA, this, you know, what...Margaret Meads, "Why would we think a small group of people would ever get anything done because, of course, that's the only way it's ever happened."

So think about what we could do, what you could do. You are in...we are all in leadership roles. We make a difference every day. The things that we do affect people's lives and our profession, and we could really do some things. So let me just give you a little bit background of what's happened in medicine and how this has progressed, and I think this might be of interest to you.

So, you remember the story about medicine. You know that in the 1800s, a lot of people in medicine were snake oil salesmen. It was a very shady thing about becoming a physician. There were no standards. The Flexner Report is what came about at the early 1900s and started saying, "We have got to have some standards for medical education," and right then, 75% of all medical schools in the country closed because they weren't equipped to be able to do things at that level of standard.

That's what happened. So there was...because it was a crisis in their discipline, medicine realized that they needed to go back to the basics of the things that really matter from a virtue standpoint or why it is that we are physicians. What is the altruistic part of what we're doing? And William Osler would have been the father of that movement and there is still a humanism move within medicine because of that, because of this idea that, "It really does matter that we do this for all the right reasons."

But after Osler's influence in the early half of the 1900s, then there was a really strong emphasis on behavioral and we've all lived this too. If you can't measure it, it can't be used to do anything. We only take those things that can be measured because if we spend time on things that can't be measured, that doesn't really help us.

And this is what our physician friends were finding in the accreditation process, is that behavioral is part of the story but it's not all of the story. Now, what's so curious about that is that right now, in 2018, there's quite a move within medicine to go to competency-based, time variable education. So that means multiple...just like our friends from Canada talked about yesterday, using multiple modes of assessment to determine performance.

Well, this is a big deal in medicine right now and because they have such a long period of time to educate their people, I think they can look at that time variability a little differently than we can in nursing but this idea of competence is big.

But in accompanying that in medicine is also this idea of what's called entrustable skills. Now, think with me on this, those of you who have had the opportunity to teach nursing students, at any level, graduate, undergraduate, have you ever been asked, "Can it be verified that this student can be trusted to do this skill unsupervised on a patient?"

Have you ever been asked that in your evaluation process? I mean, not formally, really. We really don't do that. We expose our students to skills. We give them opportunities but in terms of, "Have you moved to the point where you have done this enough, I have watched you enough. I know that you can do this,

that you can be trusted to do this particular skill without supervision," and I think about it in medicine like a thoracentesis perhaps, something like that.

So, this is what's now happening in medicine and they are talking about entrustable skills. So even though there's a competency-based time variable way of looking at things, it's not just going to be about the behaviors. It's going to be about other things that go with it and formation is a part of that. And I'll be talking mostly about that as we go forward.

So what's the current nursing conversation? Where are we in nursing about this? Well, you know our history, you know that that by and large, nursing has been taught in sacred environments. In fact, I think even now, if we would go and look at the number of schools in the country, that do baccalaureate generalist nursing education, I think we would find the majority of baccalaureate programs in the country are associated with religious institutions.

I don't think I knew that till I looked at the data on it but that is...I know in Missouri, there are more private schools than there are public. I know that in Kansas there are more private schools than there are public. And so, that's part of our history, that's part of our way of doing things, that's part of the way nursing has gone. But when we hit the 50s and 60s, the inculcation that students received in some of those sacred environments and also in secular environments, that kind of went away.

So what might have been a part of how we did what we do really moved into the hidden curriculum. So I can tell you a couple of things that my colleagues and I have done in the area of professional identity formation in nursing, one of the things that we've done is we've looked at the three main ethical traditions and made sure that all three of those are included in the model that we have.

And this is a model that is a part of the learning exchange program through national council on disciplinary action that can be used by boards of nursing. But this is the idea, is that it isn't just meeting minimum standards. You don't want that. From an ethics standpoint, we don't want that.

Look at the bottom brung here of the bottom step. It says, "Meeting social expectations and duties." And that can be deontology, continuism, that whole idea of meeting the principle of what minimum level work-related competency is. On the side of the model is reflecting on actions and consequences and, of course, that's "Utilitarianism," John Stuart Mill, "Greatest good for greatest number,"another ethical tradition that we have.

And the third is at the top, telos or ideal, and that's virtue ethics which is at the top of this particular staircase. The important part of this model is the arrows. So it means that...and this is what you mean by distributive justice, by just culture, you work with this in your field and regulation, no question.

The idea is that if you make a mistake, you are not...and this is a Jesus Christ Superstar quote, "You are not damned for all time, that you have some mechanism by which you have slipped." No question. If you have made a mistake, you have slipped.

And there are times in one's career when you are perhaps more in a slipping mode than in a flourishing mode. But if you imagine your career has this kind of an opportunity in it, where you recognize when mistakes are made, and we move from them, and we move to a point of flourishing, we're certainly not

sitting at the bottom step of that staircase and just meeting a minimum level work-related competencies.

In the state in which I live, Missouri, there are no requirements for continuing at. So someone could get a license and then never license your requirements have to do any continuing at all. So this is a model that is helpful, at least, in part of that conversation.

So we've been talking about ways in which we can expand the language of nursing and healthcare, and we can make this bigger. One example I gave you is the incivility literature and not burying ourselves in the symptoms but thinking about what can happen after that.

That's one example. What other examples? What other ways could we have ourselves be more full textured in our language about what it means to be a professional? We've already said that the term professionalism doesn't work. It doesn't work. It doesn't work when you line up Nursing faculty. It doesn't work when you line up staff.

It doesn't work. But what could we do to help that language move forward? So, the rest of my time, I'm going to spend trying to help figure out, "How can we get to some particulars?" But I think I'll let you talk at your table for just a little bit about how do we move this idea forward? How do we get more language involved about identity formation in our practice? Okay, let's hear your conversations.

Let's get three or four people who will speak in the mic and give your ideas about how we could advance this. How could we advance our language? - [Woman 3] Hi.

- Okay, shh.

- So I don't know if we made any headway in 60 seconds in this because, you know, we had 30 seconds to spare and we figured we'd solve world hunger at the same time. I think this is a very difficult conversation, a very long conversation, but at my table, I was sharing a story that they told me I should get up and say, about a physician, when I was a very young nurse, who said to me, "Once Nursing figures out what it is, you will be a force to be reckoned with but until you do that, you are always going to try to find your own identity."

And I laughed. He was a neonatologist and what do they know? They have no personality. And the longer, you know, 30 somewhat years later, his words still ring true because we don't know the answer to this convers...at least, I don't know the answer to this question and it's because, do we, as a group of individuals who have the honor of taking care of patients even know what we are or are we the identity of the organization that we work for?

Which, again, goes back to my research thing about where is your moral courage and your moral compass? Is it belongs to the organization or does it belong to your identity in the profession you decided to go into?

- Thank you.

- No answer but...

- No answer but thoughts. Yes? - [Woman 4] Hi, our table was feeling a bit of fatigue about this question and saying, "When can we stop talking about it? How do we end it?" But I wonder if it's a style of thinking, if nursing is about our critical thinking skills so we can go in and do all these things and so, can a technician, but there's a way of thinking as a nurse that we bring.

- Thank you. Yes? - [Woman 5] We talked a bit about is there an opportunity for us to look at our professional standards and why is it that we have professional standards by province, by state?

Why do we not have professional standards for a profession? Maybe across, in INRC, the international groups that we work in, and that would bring a visibility to it for nurses.

And if we expanded the language and if we took, I mean, quality assurance or whatever programs further and made them very visible and tangible, that would be a way of making the professional standards visible to nurses and help them be able to live them.

- Thank you. Thank you. Yes? - [Woman 6] I really appreciate what you're saying about using language and the image...the issue that came to my mind is how oftentimes we don't use our words, we make assumptions and we think we intuit things and we shouldn't have to say it, people should just know.

And the example that always comes to my mind is when you're in a classroom and you say, "We're going to do another small group project," and everybody groans...

- Groans, yes.

- And because it's really about the...as faculty, we make an assignment, we assign groups and we have an outcome and we assume magic's going to happen, and oftentimes, it does. And when it does, it is magical but why do we not use some language and talk about what those other competencies that we're trying to teach when we do that it's not just about the paper that somebody takes responsibility for doing all the work but it's also about negotiation, and conflict resolution, and accountability?

And if we take time, actually, people would learn both some of those outcomes skills as well as some of those process skills that if we make them more explicit with our words. So, I think, the concept of increasing our vocabulary and making things explicit could be really helpful.

- I could not have asked for better comments from you all. Thank you so much for adding to what we were talking about. I want to pick up on one thing about the institutions that we work for, have you noticed they are getting better and better at messaging? They are getting better and better at inculcating, perhaps, their employees on what the values of that particular institution are, and I think we should step up our game because it's not just about who we work for, it's about our professional identity and we've got to come up with some language that will help us.

Well, now I'm on the hunt because now we are going to move to that. So I want to share with you some of the things that we've learned from other professions, so I have to tell you the backstory of Andrew. Andrew came to this small liberal arts college that I taught at. After finishing his first year at Washington University, and some of you may not know that but at least in the Midwest, WashU is a very prominent high-end school.

He had done one year at WashU and decided he was coming to our school. Both of his parents are physicians, and he's 6-foot-7 or something, really tall guy. And he came to nursing because he heard that you only had to work three days a week. So he had some reality shock to go through when he came into the nursing program but what I want to tell you he did is he found out that working with kids with cancer was his calling.

And so, we worked really hard to get him a nurse tech physician at the children's hospital for Sutherland so that he could get that experience while he was in school and then he went to work on that unit. And now, he has finished his doctorate in nursing practice and I'll meet with him next week to find out what he wants to think about doing next.

So he came from a family environment where he had strong language skills. He had been educated well in a liberal arts environment for a year, he's obviously very articulate. Boy, we need people with different backgrounds in this field, do you know that? I mean, we really need everybody from everywhere to help our field get as multifaceted as possible, but isn't that quite a story about this gentleman?

That this is what he has done? This was years before where he is at right now. So I want to run through the information from the Carnegie study, and Dan mentioned this yesterday too. You know that the Carnegie Institute for Teaching Excellence did a study, some years ago, about the professions and they looked at law, clerg,y medicine, engineering, and nursing.

This is a fluke and this is really a game changer for nursing, I got to tell you. Because law, medicine, and clergy are the old guard 12th-century group of professions. Engineering was added, isn't this curious? Because they are the keepers of the earth. I thought that's such an interesting way to look at that, and then nursing was added because the people of the Carnegie Foundation knew Patricia Benner.

Honest-to-goodness, it was because of...and you know she, by the way, Patricia Benner was educated as an associate degree nurse who went back for her theology degree and has grown into truly one of our living philosophers in nursing, but she could communicate and could be that stake in the ground for nursing being the fifth out of these five.

There are 350 professions, folks, and nursing and medicine were both added to this study. This is incredible and it's really where nurse as advocate became part of the language. So, let me tell you what we know about that. The recommendations for nursing, there are four of them.

One, we need to teach with a sense of salience. So, in other words, not nice to know stuff. We need to get to need to know. We need to connect clinical and classroom teaching. We need to move our language from the term critical thinking to clinical judgment and that's Christine Tanner's work from Oregon. And that is really...that shift is probably coming.

And then the fourth area, and this is the one that's underdeveloped since this came out in...since this book, which you might be aware of, came out in 2009. The one is, Move from an Emphasis on Socialization: How the GroupActs and Role Taking to One of Formation. So it's not so much how the group acts, it's how do you act when no one else is watching and that's what formation is.

Okay. So this is one of the reasons our surgeon friends at McGill wanted to move it to a term of formation, identity formation, rather than just taking on the role. That's not enough. It's not enough for the story. So you might be interested to know what the recommendations were for medicine.

They had four as well. they needed to integrate their curriculum better. Right now, they two years...generally, do two years of classroom time and then two years of clinical application. Second was professional identity formation. The only time when the same recommendations were given to any of those five groups was with formation.

The only time is with that. then a suggestion about standardization and individualization, so some kind of mix rather than just a cottage industry of how people are taught and then inquiry, innovation, and improvement. And actually medicine has done a pretty good job of jumping on this. The other recommendations they gave for medicine, and I'm sure you're not surprised about this, formal instruction in ethics and reflective practice and, you know, that could also follow through the nursing.

I'm not sure every school does ethics. I'm not sure. Exploration of the role of being a physician citizen not just plugging in and doing your work but how is it that you're a part of the community, the society and then more supportive learning environments? And now that I'm at an academic health center, not just ours, but as I listen to what other people are doing, there's a lot of work to be done in being supportive of medical students and residents by their educational environment.

It's just like they say. So formation is about those changes in identity and self-understanding that occur in moving a lay person to a professional and that we need to look at fostering and forming this within our discipline.

So I want to make the case for an intentional approach. So here comes the sale, I guess. I want to make a case for an intentional approach. And back to my friends at McGill, these two physicians, they got involved with LCME, which is the accrediting agency for medicine, and they said, "We need to have some standards about identity formation in school.We need to have some standards."

And they were a loud voice and they gathered some of their colleagues and there's a lot of conversation about education that takes place in medicine. They have 124 schools, by the way, in case you wanted to know, 124 schools nationally in North America. But it was a small group of people that said, "This needs to be part of the accreditation process." So there's room for us.

And I have another case study for you to take a look at before we move to those points. Nurse L. works an extra hour finishing paperwork at her job, drives the 20 minutes home only to arise from six hours of sleep, at 6:00 a.m., to shuttle her son to an out-of-town soccer game.

The day is just beginning, upon arriving home from the soccer game, Nurse L. moves to definitely and deliberately go through the long list of to-do's. She's a single parent with no one else to help her with her chores, life feels like a blur. "My life," she thinks, "Is like cramming five pounds of potatoes into a two-pound bag." And, you know, I'm bringing this up again, aren't I?

And why am I bringing this up? Because when we look at people who are doing direct care, the data

says that 70%of RNs are the main breadwinner in their homes. And when you have the opportunity to increase your income by working more and you have those income needs, sometimes that's what you end up doing.

So if we are going to be responsive, we can't sit in the ivory tower and keep talking about professional identity and not recognize where people are living and what we can do about it. So, I think that...we don't have time to talk about it but I think the question is what is it we do in our institutions to help ameliorate it?

I mean, even if you're in a Board of Nursing, you've got people with RN behind their name working in your organization and life happens and there are really tough times and how do we support them in that? Well, I hope we do a really good job of that but that does not happen in every environment. And now that we've been much more aware of toxic work environment, I think we addressed it more than we used to, but I don't know about your area, but we are short, short, short on staff.

And so the idea of looking at coaching people to another position is pretty difficult. I mean, we're in a box again, at least I speak practically from where we're at with it. But I want to bring this out because I think this is part of our reality. Also, part of our reality is what happened with the Magnet movement that began in 1983.

And while you know there's only 6% of hospitals that are Magnets, there's about 20% that are Magnet-like and aspire to those kinds of goals, and criteria, and what is magnet about. Magnet is about what acts as a magnet to keep nurses working in an institution.

It's about, how do you have nurses that give you a 7% turnover rate? How do you get to that? And sometimes Magnet has a mechanism for that but, at least, the thing I want to say about this is this is telos. This is virtue. This is, what can we do? This is the ideal. So don't we all need that?

Don't we all need some aspirational way of going about this? If we're just doing transactional work, it wears thin. If you are a staff nurse on a tele step-down unit and you are being talked to all the time about standard work and only standard work, and no one's talking with you about research intern opportunities or other opportunities, I mean, don't you kind of go dry too?

You have to be thinking about other things that can happen. So we can influence these things. We can influence them. So when we act as coaches, this is what we have to do. When we see the revealing reality in front of us, we've got to make this clear to those people who aren't in the same meetings we're in.

So this is a Porter-O'Grady and Mallach quote that I love, "The goal of coaching is to help people acquire new ideas that validate the experience of change and more accurately reflect the revealing reality ensuring they have a place in it." So what works? Here's what the research says, this is what works in identity formation for medicine and I'm considering them our colleagues in this because they have approached this.

So this is the laundry list of that: formative assessment, student feedback, guided reflection, role modeling, supporting student behaviors, competency and formation, and attention to e-professionalism,

which is the social media piece. What works in the nursing literature?

Focusing on students' perception of their own caring, intentional education on identity formation, attentional education and fostering of self-concept, decreased role stress, building resilience, a sense of belonging.

And by the way, belonging shows up everywhere. Belonging and role modeling are the two things that show up all the time, and then being engaged while you're in school and nursing related work. So, I have two models to show you. This is what the medical people do when they talk about teaching.

They go first to, what do you know? I think this is so curious. I think we ought to think about it. What do you know? What do you know how to do? What can you show how you do, and what can you do? We're not at that place, at least, in beginning nursing, we don't do this to this degree.

But my friends in Montreal say that there's another on the top which is about identity. So, you can know something, you can know how to do something, you can show me how you do something, you can do something, but it's also about how you are, your being.

The bottom four are about doing, and the last one is about being. And if we don't make sure that we have that in our conversation, we're not going to have a place to go. So my last slide is this, is a Saint Exupéry quote that I just love. So if you want to encourage people to teach or go into nursing, here's what I would say, "If you want to build a ship, don't drum up the men to gather wood, divide the work, and give orders. Instead, teach them to yearn for the vast and endless sea."

So I've left time for questions and comments because what I'd really like to have happen is for us to have some ideas on how to mobilize this. I told you a story about our school through a tortuous process, adding seven credits in a curriculum on professional identity formation. The first course is introduction to the profession.

The second is ethics, image, and values. The third is navigating the profession. We have helped our students with that kind of focus, that's just one way of doing it. What about from a regulatory standpoint or what about from a practice standpoint? What about from education? - [Woman 7]

Hi, there. Thank you very much. I thought it was a great presentation and I come from Alberta and I'm part of the College of Licensed Practical Nurses there and I'm a Director of Policy and Research. And we've done a study, and this is just a comment mostly but a very interesting aspect of discourse around a profession. We were doing a historical look at the LPN profession in Alberta.

So it's been around for about 70 years, started post-war, like a lot of professions did when there was not enough healthcare workers and the need for them. And we came across a letter that was written to the Minister of Health, at that time, by the head nurse of the health system, I suppose, the Chief Nursing Officer. We don't even have those anymore in Alberta.

So, anyway, the chief...she had written a letter to explain why we needed this profession called LPNs in Alberta or vocational nurses, and the letter said, "This is a good profession for girls that are too simple to be teachers and not pretty enough to be married." I think starting a profession like that leads to a long,

long time to get to be kind of underlying discourse over the years and, I think, we've suffered from that and that's the way that that profession was kind of gauged within our health system for a long time.

I think we've changed that. I think we've come 1,000 times, you know, over into learning about being professional and conducting ourselves that way but there's always that little inkling about, "Are we not good enough?" Because this is how we were founded, and I often think about that and try to undo that discourse. And I think it's probably true for nursing in general, in some ways. So, just something to think about.

- Yes, I think we're the last profession to be in that spot, you know, who else does this gender imbalanced? I don't know. I'd always thought maybe by the time I died, you know, we'd have 50% men and 50% women. I just don't think it's probably going to happen, but boy, wouldn't we like that? Yes? - [Woman 8]

I'm sort of stuck back on Nurse L because I don't see...first of all, we're still mostly women but I don't see a path for her in our discussion about professionalizing. Several things need to change in nursing but how do we transform her life that enables her to practice in a way where she can have some joy in it?

- Yeah. One of your...your comment about joy a while ago too.

- Yeah.

- Yes. I think...so, great. I picked a hard one. That's exactly why I put that in there because it's so difficult. So can we...we want to hear what you have to say but folks, try to respond to what she just brought up. I think we should talk about it. -

[Woman 9] You know, I think education is key because I have a clinic and I always invest money budgeted for education and trips to go out, you know, for the fun stuff, to learn about EMRs, things like that and it's expensive, but I think it adds value. It gives them an extra edge amongst their peers and I think education is just key to everything. And I'm so great for National Council that have this ROA program because I know it costs a bunch of money but to invest in the future is paramount because it gives you the oomph to kind of move forward.

So even if...you know, and you can't take that away from you. So, I think, education is invaluable, and I think that nursing, you know, especially when we're taking care of our young, we need to invest in that, and even for the old. I was hearing yesterday that there were some senior nurses that may not have had a chance to get their masters or their doctorates but creating programs that will allow them to go back to school, for free, you know, and investing in that wisdom, because there's so much of value in having these older nurses.

So I think just bringing the young and the old together and, you know, not just feeling like you're indispensable that somebody else is going to take your place but really adding that value piece across the continuum because in Mass, we are over, like, 5 million nurses or something and that's a huge force to be dealt with but I think that we need to step up and embrace that.

- Great point. Someone want to pick up what she had said about how do we help this nurse? - [Woman

10] I just keep thinking we keep talking about top-down and what do we do for her? But I think we've had some conversations yesterday and at previous conferences about the importance of peers, and peer review, and peer support, and peer networks to help support everyone in their profession because sometimes it's easier if it's coming from peers and peer support than a top-down.

- Good point. I can tell you that one of the themes in the medical literature right now is about resident empowerment. Who in the world would have thought residents needed empowerment? I mean, and I'm not being silly about it, it's just that that didn't even crossed my mind.

Why would residents need to be empowered? And the fact of the matter is they're in stressful situations trying to get the best thing done for the patient, trying to make a system that works well and sometimes not so well to have that happen, and dealing with attendings that may or may not be interested in teaching them.

So, I thought that was so interesting that it was about resident empowerment. I would argue that this nurse probably could use some empowerment herself, maybe that's part of the terminology that we could use. Yes? - [Woman 11] Thank you. I really enjoyed your presentation.

My question or comments have to do, coming from a little different perspective. With Institute of Medicine report on "The Future of Nursing," and the importance of leadership in Nursing, and Nursing beginning to look at what we do as a profession in terms of the economic piece of what we bring to the puzzle because that, over the years, that has been really hard for us to quantify.

And we know that in today's world, as you mentioned, that means a lot when we're talking about being at the table. And so, from that perspective, in looking at both scenarios, and remember when I was in school, one of the things that I was told is that, "When you enter that hospital or that patient's room, you can't bring your problems. Your focus should be on that patient."

And so, when our institution...our agency hires that nurse or that nurse is a student in school, there are expectations that you're going to provide a specific service and be able to care for the patients or be able to educate the student, and so sometimes, it's very difficult.

We talked about incivility and the fact that we're predominantly female profession and how does that relate to the rate of incivility in our profession? It's just that...I think that we have to come from a perspective that we are a profession and what a...we're saying in terms of physicians, which maybe is predominantly still male, would they have the same expectations that with that physician, "I'm a single father and I'm having these issues, so I need to help support..."?And I'm saying that that's wonderful but can that agency still has an expectation or that hospital still has an expectation that you're coming to the plate ready to administer care and provide service, safe, effective, high quality service, which is what we're saying that Nursing brings to the table.

- Well, one of the facets you're bringing up is, what does this do to the organization when you have people who are like this working beside you? I mean, we've all done that too. I've done that too. And that's not good for the organization, it's not good for the other staff. Yeah, I think we've got ways to go on this yet. And I want to hear what you have to say, so I will, but just stay there.

But I've got five minutes left with high-powered regulators and nurse leaders in the country, what can we do to move this needle so this becomes part of our conversation and our follow through either in practice or in education or both? So, we'll save that, you say your point, and then we'll see if we can get any responses to that.

- [Denise] Well, one of the things that struck me... Well, my name is Denise and I'm from Texas. One of the things that struck me in both of these scenarios is an underlying shift that we've seen in the practice environments as nurses working 12-hour shifts. And when you read in the literature, back in the early 1900s, I think it was sometime between 1900 and 1910, The American Journal of Nursinghad an article about nurses working 12-hour shifts and they were so glad that the hospitals had finally introduced 8-hour shifts.

And so, if we don't look back at our history a little bit so that we learn our lessons from the past so that we can advocate for what is best for the nurses today, we're going to repeat the same mistakes that were made...

- Yeah, very good point.

- ...in the past and I wonder if the 12- hour shifts contributed in both of these scenarios to the nurse being fragmented or thinking about their own work life.

- I'm so glad you brought that up because we hadn't addressed that until now. You know, I am impacted. I want to tell you, personally, I am impacted by looking at the literature on incivility because I've spoken on that and written on that.

I mean, it's not something I'm not unfamiliar with but when I saw that number of research articles in incivility in Nursing, it really brought me up short. So, I want to tell you what we're getting involved in and invite you, if you want to be part of this. Back in the old days of Nursing, Martha Rogers was one of our theorists. Well, she would have little afternoon meetings, salons, or whatever where she'd invite graduate students and they talked about theory and unitary something of, man if I remember right, I wasn't a Rogerian theorist but...

We are going to do that kind of a create the space think-tank on September 16th and 17th in Kansas and it's going to be on professional identity formation in nursing and how can we move this forward. We're not going to make any money off of it. We've decided that we're just going to charge what it takes.

But I just want to know if you are one of those people who really would like to see how we can move that forward, get in touch with me. This is very low-key, I'm not advertising it. I'm just really telling you that don't you think we probably should get some smaller conversations together so that we can change some of this in some way? Otherwise, I don't think it's going to get addressed and we're going to get steamrolled by outcomes and we're not going to have any space, and I worry about that for our profession.