2018 NCSBN Annual Institute of Regulatory Excellence (IRE) Conference - The Interprofessional Movement to Foster Professional Identity Formation in Nursing Education Video Transcript

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

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Presenter
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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.

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 loo-2 (i-2 (ha) (a) 4 (t)doe) 4 (s) 9 (,) -10 150 -8 150 A ET Q(t) -2 (he0 (

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.

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

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.

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,

- No answer but thoughts. Yes? -

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

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.

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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

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.

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