

Reflections: The Responsibility of Doctoral Nurses to Lead a Change in Practice

Theme: Evidence-based practice

Contribution to the discipline: It is important to highlight the responsibility that nurses with a Ph.D. qualification have to promote innovation in practice and stimulate other professionals to use practice based on scientific evidence, as well as generate contributions to health policies, maintaining critical and creative thinking in the solution of problems.

ABSTRACT

This paper aims to consider the responsibilities of doctoral nurses to lead changes in practice through a very personal reflection of over 52 years in nursing. The reflective learning moves from an early training experience where I learned to 'do' to becoming a nursing professor with a doctoral qualification and an 'evidence-based doer.' The change witnessed has been considerable. As the highest educated professional, I have learned that doctoral nurses are responsible for leading and directly influencing clinical practice, either as a practitioner, an educator, or a researcher. They are capable of encouraging the development of critical thinking skills and helping practitioners to be curious, take risks with ideas, identify gaps in the evidence base, and be creative in their problem-solving. If the strategic vision for nurses globally is to provide the best quality of patient care, then evidence-based practice is key to leading from the head, hand, and heart. Doctoral nurses understand the patient benefits of a high staff-to-patient ratio and having a critical mass of university qualified nurses and must strive to influence policy to this effect. As each country, particularly in Latin America, develops a critical mass of doctorally qualified nurses, then they can harness their innovation, create new ways of working, attract them back into practice, and strengthen their political voice to lead strategic change. Doctoral nurses must develop their leadership skills and their confidence to lead. They have a responsibility to realise their potential and identify the opportunities to really make a difference.

KEYWORDS (SOURCE: DECS)

Leadership; practical nursing; nursing education; graduate education; nursing; nurse practitioners; evidence-based practice.

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Reflexiones: la responsabilidad de las enfermeras con doctorado de liderar un cambio en la práctica

RESUMEN

El presente artículo tiene como objetivo considerar las responsabilidades de las enfermeras con doctorado de liderar cambios en la práctica a través de una reflexión muy personal de mis más de 52 años de experiencia en enfermería. El aprendizaje reflexivo transita de una experiencia de formación temprana en la que aprendí a “hacer” a convertirme en una profesora de enfermería con un título de doctorado y en una enfermera que actúa “con base en la evidencia”. El cambio que he observado ha sido enorme. Como profesional con el más alto nivel educativo, he aprendido que las enfermeras con doctorado son responsables de liderar e influir directamente en la práctica clínica, ya sea como practicantes, educadoras o investigadoras, pues son capaces de fomentar el desarrollo de habilidades de pensamiento crítico y de ayudar a las practicantes a ser curiosas, a tomar riesgos en las ideas, a identificar lagunas en la evidencia y a ser creativas en la resolución de problemas. Si la visión estratégica de las enfermeras a nivel mundial es brindar la mejor calidad de atención al paciente, entonces la práctica basada en la evidencia es clave para liderar desde la cabeza, la mano y el corazón. Las enfermeras con doctorado comprenden los beneficios de contar tanto con una alta proporción de personal por paciente como con una masa crítica de enfermeras con título universitario y, por lo tanto, deben esforzarse por influir en las políticas para este fin. A medida que cada país, en particular en América Latina, desarrolla una masa crítica de enfermeras con doctorado, puede aprovechar su innovación, crear nuevas formas de trabajo, atraerlas nuevamente a la práctica y fortalecer su voz política para liderar el cambio estratégico. Las enfermeras con doctorado deben desarrollar sus habilidades de liderazgo y su confianza para liderar, puesto que tienen la responsabilidad de desarrollar su potencial e identificar las oportunidades para marcar la diferencia.

PALABRAS CLAVE (FUENTE: DECS)

Liderazgo; enfermería práctica; educación en enfermería; educación de postgrado; enfermería; enfermeras practicantes; práctica clínica basada en la evidencia.

Reflexões: a responsabilidade das enfermeiras com doutorado de liderar uma mudança na prática

RESUMO

O objetivo deste artigo é identificar as responsabilidades das enfermeiras com doutorado de liderar mudanças na prática por meio de uma reflexão pessoal com base nos meus 52 anos de experiência em enfermagem. A aprendizagem reflexiva transita de uma experiência de formação precoce na qual aprendi a “fazer”, a me tornar uma professora de enfermagem com título de doutorado e uma enfermeira que atua com base na evidência. A mudança que venho observando é enorme. Como profissional com mais alto nível educacional, aprendi que as enfermeiras com doutorado são as responsáveis por liderar e influenciar diretamente a prática clínica, seja como profissionais da saúde, seja como educadoras ou pesquisadoras, pois são capazes de fomentar o desenvolvimento de habilidades de pensamento crítico e de ajudar as profissionais da saúde a serem curiosas, a correr riscos com suas ideias, a identificar lacunas na evidência e a buscar solução de problemas. Se a visão estratégica das enfermeiras no âmbito mundial é oferecer melhor qualidade de atenção ao paciente, então a prática baseada na evidência é fundamental para liderar a partir da cabeça, da mão e do coração. As enfermeiras com doutorado compreendem os benefícios de contar tanto com uma alta proporção de pessoal por paciente quanto com um corpus crítico de enfermeiras com título universitário e, portanto, devem se esforçar por influenciar as políticas para esse objetivo. À medida que cada país, em particular na América Latina, desenvolve um corpus crítico de enfermeiras com doutorado, pode aproveitar sua inovação, criar formas de trabalho, atraí-las novamente para a prática e fortalecer sua voz política para liderar a mudança estratégica. As enfermeiras doutoras devem desenvolver suas habilidades de lideranças e sua confiança para liderar, visto que têm a responsabilidade de desenvolver seu potencial e identificar as oportunidades para fazer a diferença.

PALAVRAS-CHAVE (FONTE: DECS)

Liderança; enfermagem prática; educação em enfermagem; educação de pós-graduação; enfermagem; profissionais de enfermagem; prática clínica baseada em evidências.

Introduction

Having celebrated 52 years in nursing, I reflect on my nursing career and observe how nursing has come of age. In the space of my lifetime, many countries have moved to becoming a degree qualification as compulsory for professional nursing. Additionally, there are many master's and doctoral qualified nurses across the world with most countries now offering them positions as professors of nursing at the highest academic level of the university, once they have achieved the requirements for such a role. This is indeed progress and unheard of when I commenced my training. Nevertheless, many countries still organise their healthcare with few professional nurses supervising a mostly unqualified workforce. Therefore, as nursing practice attempts to keep abreast of the scientific and technological changes, education to lead is key to ensure that nursing practice follows the evidence base to avoid a theory-practice gap. Through my reflections, this paper will explore the role of the doctoral nurse to lead changes in nursing practice.

Globally, doctoral education for nurses is relatively new. University undergraduate degrees were introduced in the USA in the 1920s to prepare professionally qualified nurses, and it was many years later before other countries followed. Once nurses were prepared with baccalaureate degrees, there was the need to ensure that nurse educators held higher qualifications, and thus master's and doctoral programmes were developed. Anthony et al. (1) identify the first dedicated nursing doctoral programme by Columbia University, New York, in 1934, with other universities quickly following suit. The first in the United Kingdom (UK) was in 1967, and over several decades, doctoral programmes in nursing developed in Australia, Brazil, China, Japan, Jordan, and Korea (1). Apart from Brazil, which introduced its doctoral programme in 1979, most Latin American countries began their doctoral programmes in the early 2000s, but most of them remain with only one programme in their portfolio (2).

Why do we need doctoral nurses?

The question must be asked, why do we need nurses to be educated to doctoral level? The Quality Assurance Agency in the UK (3) identified the characteristics of a doctoral qualification. Principally, it recognised the professional need to generate a body of knowledge to improve the quality of care. Additionally, with many countries requiring professional education in institutes of higher

education, universities are interested in developing their research leadership. However, perhaps most importantly, through doctoral education, clinical nurses need to develop their critical thinking skills, identify gaps in the evidence base, take risks with ideas, and be creative and imaginative in their problem-solving.

Primarily, doctoral education aims to prepare nurse scientists as leaders in nursing practice, education, and research. In my own early years as a nurse, there was very little evidence base for nursing practice, which was mostly based on intuition and tradition. Generally, nurses did not research as they did not have the education to do so. Nursing was a very practical occupation. Only when doctoral preparation became common practice were nurses and importantly others able to take their leadership seriously as they spoke from the same educational level as others across the healthcare professions and within the university system, capable of logical, evidence-based argument and above all, critical thinking. As the UK Quality Assurance Agency (3) acknowledge, doctoral education offers the ability for nurses to lead in a dynamic way. With the unprecedented pace of change in the world and the need for nurses to be responsive to the new workplace environments, which require them to question existing assumptions, doctoral education can provide nurses with the skills to analyse trends and create a vision that sees the bigger picture (3). Indeed, as clinical nurse leaders need the vision to transform nursing practice, it is their capacity to translate that vision into a reality that validates their leadership.

Vision for nursing

As I reflect over the past 52 years, the vision for all nurses has always been to strive towards the highest quality of patient care. However, as we travel through this technological age and the world of healthcare changes at a pace, the evidence to support that quality is continually changing. So, if we interpret 'vision' to be the ability to imagine the future that at present does not exist, what is it that will help us to translate that vision into reality?

Having spent six years leading a small community hospital in a remote village in Colombia without access to the internet or up-to-date textbooks, I was hungry for knowledge. I felt my leadership lacked the latest evidence on which to base my practice, and I returned to London, England, to take a specialist course with the idea of returning to lead 'knowledgeably'! However, in London, the nursing theory was beginning to take shape, and the

UK had adopted the nursing process, nursing theory, and nursing models mainly from the USA. The concepts were completely new to me, and I was keen to learn more. I soon studied for a Master's in Nursing programme, of which one year of the three-year programme was devoted entirely to nursing models, originally developed by the early doctoral nurses in the USA.

However, more recently, the models were heavily criticised and since the early 2000s in the UK, they fell out of favour. What they attempted to do was to help us to translate our vision into reality. Each model reflected a different way of looking at the patient. Rather like a model aeroplane or motorcar, nursing models helped us to explain our nursing reality and, according to Burns et al. (4), each nursing model contained the following components to advance nursing knowledge:

1. A set of beliefs and values
2. A statement of the goals and assumptions about nursing

So, each model or conceptual framework illustrated that the beliefs and values underpinning the care of diverse patients might be different, leading to a different goal for each patient and so varying the knowledge and skills required. Considering the bigger picture, the practice of nursing locally, nationally, and globally differs. It is also culturally dependent, e.g., nursing practice in the heat of the tropical coast of Colombia with reduced resources is, in my own experience, different from nursing in the cool mountainous urban regions of Bogota and different again between the remote village community where I worked and the private hospital in Cartagena where I moved to. Therefore, the reality that nursing models are trying to represent will be different in different parts of every country and across different countries, and I am sure, quite different from the 1960s in the USA when the models were developed.

From my own experience, different countries are developing their own philosophical (beliefs and values) approaches to guide practice, and these, in turn, will impact the different nursing goals and the subsequent knowledge and skills required of them. As an example, there have been a number of atrocities occurring in the UK National Health Service which have influenced the development of a country-wide philosophy promoting person-centred care and compassionate care. This occurred as a direct result of one hospital where many patients lost their lives unnecessarily due to their focusing on measurable targets rather

than the quality of care (5). It is the doctoral nurses who are developing these philosophies and frameworks both through their research (6) and their teaching. It is the doctoral nurses who are best positioned to think critically and creatively through their research and teaching to guide nursing practice, and they have a responsibility to do so.

The importance of evidence-based practice (EBP)

Once the doctoral nurses have developed their philosophical visions, we need to explore what we mean by the quality of care. As Rosser et al. (7) acknowledge, practice based on best evidence offers the best quality care; they indeed noted that nursing's regulatory body in the UK, the Nursing and Midwifery Council, states in their standards for professional nurse education throughout the UK that all nurses must "safely demonstrate evidence-based practice in all skills and procedures... [and] demonstrate the knowledge, skills, and ability to think critically when applying evidence" (8). Additionally, from an education perspective, Rosser et al. (7) recognised the universal commitment of nurses to EBP, certainly in the western world, though they acknowledge that the support structures in practice are often lacking.

Sackett et al. (9), who instigated the EBP movement in medicine in the 1990s, explained EBP as not merely the evidence from research but ensuring that the best quality care embraces a combination of knowledge for the head (technical knowledge based on research evidence), knowledge for the hand (professional and life resources), and knowledge for the heart (first-person accounts of patient experience) (10). Otherwise, nursing care will be based on tradition and often on the command of others and be possibly harmful. So, it is important to understand that EBP is based on a combination of all three types of evidence and not merely research.

In spite of the widespread acceptance of EBP, there remains much resistance to its continued adoption (7). Although it is the responsibility of all nurses to support the implementation of EBP, it is those doctorally educated nurses who are responsible for the leadership. Hence the need to recognise the Institute of Medicine in their report on the Future of Nursing, as reported by Luckett (11) too, which advocates increasing the number of doctoral nurses in the USA and for nurses to practise at their educational level. Strategically, it is those doctoral nurses who have the education to develop the evidence base on which to change nursing practice

for the better, create nursing philosophy and theory to guide nursing practice, and assist governments at the policy level to improve the health of the population. More importantly, at the clinical practice level, doctoral nurses should be influencing the creation of new roles in practice, contributing to new ways of working in light of best practice recommendations to improve the quality of care, be cost-effective, and be leaders in the practice environment.

Traditional ways of working fail to attract doctoral nurses at the bedside. So, it is essential that new roles to influence practice are created that advance the role of nurses who understand the patient perspective and assist those in practice to overcome the resistance to change. Due to the lack of ability to sustain good senior nurses at the bedside within the UK and elsewhere, the government introduced the role of the Nurse Consultant, the highest level of clinical nurse in the country. The Nurse Consultant is positioned at the same level in the hospital hierarchy as the medical consultant and is involved in strategic decision-making at the organisational level. Nurse consultants' time is divided as follows: 50% of their time in patient contact and the remaining 50% divided between leadership, service development, education, and research. They are increasingly required to have a doctoral qualification. Consequently, doctoral nurses become motivated to remain at the bedside and have a clearly mapped out role in influencing and leading direct care as well as leading nationally at the policy level. They are skilled practitioners yet have a role in clinical research as well as in education.

Creating autonomous and leadership roles at the bedside assumes that there is a critical mass of professional nurses in clinical practice able to understand the importance of EBP and supervising and leading others in its implementation. However, many countries have very few professional nurses in clinical practice, and practice is supported by an unqualified workforce. Aiken et al. found in their study of nursing staff in nine hospitals across Europe that

each increase of one patient per nurse is associated with a 7% increase in the likelihood of a surgical patient dying within 30 days of admission, whereas each 10% increase in the percent of bachelor degree nurses in a hospital is associated with a 7% decrease in this likelihood. These associations suggest that patients in hospitals in which 60% of the nurses had bachelor's degrees and nurses cared for an average of six patients would have almost 30% lower mortality than patients in hospitals in which only 30% of the nurses had bachelor's degrees and nurses cared for an average of eight patients. (12, p1828)

Although not representative of other contexts, it is strong evidence to suggest that nurses' educational qualifications and the nurse-to-patient ratio seem to have a direct impact on the outcomes of hospital patients, reinforcing the importance of having a critical mass of professional nurses on duty at the same time and that they have an undergraduate degree qualification. With this evidence, doctoral nurses must influence government policy at a strategic level to ensure an adequate nurse-to-patient ratio for the survival of their patients.

Additional to creating leadership roles in clinical practice, doctoral nurses have a responsibility to support interprofessional working. Since 2010, the World Health Organisation (13) has advocated the importance of interprofessional working, recognising the weight of evidence to support the need for effective interprofessional education, which in turn enables effective collaborative practice, strengthens healthcare systems, and improves health outcome. Additionally, interprofessional collaboration helps prevent medication errors, improves the patient experience, and ultimately reduces healthcare costs. As leaders in practice, education and research, doctoral nurses are well placed to take the responsibility to lead the ongoing move to effective interprofessional collaboration (13). Finally, unlike the US, student nurses in the UK are supervised and formally assessed as competent by practice assessors. It is the responsibility of the professional nurses to determine a student's competency to practise and not the educationalist. In this way, doctorally qualified nurses in senior clinical roles can influence professional practice by raising the standards in each clinical area.

The importance of self-leadership

Having identified the importance of doctoral nurses taking responsibility for leading changes in clinical nursing practice, it is worth considering what this means for the individual. Reflecting on my own career, after completing my doctoral degree, I cannot say that I felt any more of a leader than before. Whilst there are many leadership theories to draw upon, the importance of collaborative leadership is gaining recognition. Given the complexity of today's health and social care, the days of individual 'superheroes' have long gone, requiring a much more collaborative model of leadership. Nevertheless, I recognised the importance of myself stepping up to face the interprofessional team as an equal partner to contribute meaningfully to the team. I recognised the importance of self-leadership. I had to find that self-leadership in myself

while my team looked to me to take the lead in day-to-day decisions and collaborate when appropriate. I recognised the need to think and work differently and work from deep within me. Thinking about myself differently, I needed to influence myself to create the direction and motivation to perform and change my behaviour as a result of the way I began to think. I needed to empower myself to lead. I recognised my responsibilities as a doctoral nurse. It is imperative to know your own scope of practice, when to lead and when to follow. I invite you to step up and feel that inner strength to lead.

Conclusion

I have shared my reflections on the importance of doctoral nurses as leaders and the cultural context of their vision. Nevertheless, high-quality care is the same vision that nurses have across the globe, and we need to understand better what this means for us, using knowledge from the head, hand, and heart. As a doctoral nurse, you have the knowledge and capability to lead in whatever speciality you care to focus, whether that be education,

research, or practice. Recognising the patient benefits of a critical mass of professional nurses in practice, the importance of a high staff-to-patient ratio by staff who have a university bachelor degree can save lives (12).

As each country, particularly in Latin America, gains a critical mass of doctoral nurses, then they will become more inventive in their ability to create new ways of working, integrate new technologies clinically, innovate new roles, and ultimately attract doctoral nurses back into practice. Through collaboration, doctoral nurses can learn from the international community, and by educating nurses at all levels to find their political voice, they can become visible at their country's strategic leadership table and ultimately realise radical change. Nurses know what they want to achieve and are innovative professionals. Through the leadership of doctoral nurses back into practice, now is the time to empower nurses to think differently, to change practice at a strategic level, both at a national and organisational level, but also to lead the quality of care based on evidence. You are nursing's future; please see the challenges ahead as opportunities to really make a difference.

References

1. Anthony D, Alosaimi D, Dyson S, Korsah KA, Saleh M. Development of Nurse Education in Saudi Arabia, Jordan and Ghana: From Undergraduate to Doctoral Programmes. *Nurse Educ Pract*. 2020;47:102857. DOI: <https://doi.org/10.1016/j.nepr.2020.102857>
2. Organización Panamericana de la Salud y Organización Mundial de Salud. Formación doctoral en enfermería en América Latina y el Caribe. Washington; 2017 [cited 2021 Apr 15]. Available from: <https://iris.paho.org/handle/10665.2/34312>
3. The Quality Assurance Agency Characteristics Statement: Doctoral Degree, United Kingdom; 2020 Feb [cited 2021 Apr 8]. Available from: https://www.qaa.ac.uk/docs/qaa/quality-code/doctoral-degree-characteristics-statement-2020.pdf?sfvrsn=a3c5ca81_14
4. Burns M, Bally J, Burles M, Holtslander L, Peacock S. Influences of the culture of science on nursing knowledge development: Using conceptual frameworks as nursing philosophy in critical care nursing. *Nurs Philos*. 2020 Oct;21(4). DOI: <https://doi.org/10.1111/nup.12310>
5. Francis R. Report of the Mid Staffordshire NHS Foundation Trust, Public Inquiry; 2013 [cited 2016 Apr 24]. Available from: <http://www.midstaffpublicinquiry.com>
6. McCormack B McCance T, editors. *Person-centred Practice in Nursing and Healthcare: Theory and Practice*. 2nd ed. Chichester, UK: Wiley Blackwell; 2016.
7. Rosser E, Neal D, Reeve J, Valentine J, Grey R. Evidence-based practice as taught and experienced: education, practice and context. In: Lipscomb M, editor. *Exploring Evidence-based Practice: Debates and Challenges in Nursing*. Abingdon, Oxfordshire, UK: Routledge; 2016. DOI: <https://doi.org/10.4324/9781315764559-4>

8. Nursing and Midwifery Council. Standards of proficiency for registered nurses. London: Nursing and Midwifery Council; 2018 [cited 2021 Apr 9]. Available from: <https://www.nmc.org.uk/globalassets/sitedocuments/standards-of-proficiency/nurses/future-nurse-proficiencies.pdf>
9. Sackett DL, Strauss SE, Richardson WS, Rosenberg WMC, Haynes RB. Evidence-based Medicine: How to Practice and Teach EBM. London: Churchill-Livingstone; 2000.
10. Wright TA. Distinguished Scholar Invited Essay: Reflections on the Role of Character in Business Education and Student Leadership Development. *J Leadersh Organ Stud*. 2015;22(3):253-264. DOI: <https://doi.org/10.1177/1548051815578950>
11. Luckett TY. A Motivational Profile of Nurses Who Pursue Doctoral Education [dissertation]. Long Beach, Mississippi: University of Southern Mississippi; 2017 [cited 2021 Apr 10]. Available from: <https://aquila.usm.edu/cgi/viewcontent.cgi?article=2347&context=dissertations>
12. Aiken LH, Sloane DM, Bruyneel L, Van den Heede K, Griffiths P, Busse R, Doimidou M, Kinnunen J, Kózka M, Lesaffre E, McHugh MD, Moreno-Casbas MT, Rafferty AM, Schwendimann R, Scott PA, Tishelman C, Van Achterberg T, Sermeus W. Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *Lancet*. 2014 May 24;383(9931):1824-30. DOI: [https://doi.org/10.1016/S0140-6736\(13\)62631-8](https://doi.org/10.1016/S0140-6736(13)62631-8)
13. World Health Organization. Framework for Action on Interprofessional Education & Collaborative Practice. Geneva; 2010 [cited 2021 Jan 1]. Available from: https://apps.who.int/iris/bitstream/handle/10665/70185/WHO_HRH_HPN_10.3_eng.pdf;jsessionid=ADA0EA9576640CA76AA0AA491FC4974B?sequence=1