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(Re)defining nursing leadership: On the importance of *parrhèsia* and subversion

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Abstract

Aim: Through a review of philosophical and theoretical constructs, this paper offers insight and guidance as to ways in which nurse leaders may operationalize advocacy and an adherence to nursing's core ethical values.

Background: The US health care system works in opposition to core nursing values. Nurse leaders are obliged to advocate for the preservation of ethical care delivery.

Evaluation: This paper draws upon the philosophies of Fromm, Foucault, and Deleuze and Guattari to critically review the functions of nurse leaders within a capitalist paradigm.

Key issue: Key emergent issues in the paper include health care and capitalism and the nurse leader's obligations towards advocacy.

Conclusion: The nurse leader acts as parrhèsia in viewing truth telling as a duty critical to improving the lives of patients. Ramifications of the decisions by those in power have even greater impact in institutions that serve those with little to no political agency.

Implications for Nursing Management: The nurse leader has a freedom and platform that their patients do not and must take the courageous risk of choosing to speak. This paper serves as a call to action for nurse leaders to urgently address the current state of US health outcomes.

KEYWORDS
capitalism, ethics, leadership, management, power, theorists

1 | INTRODUCTION

As the United States continues to suffer the effects of the COVID-19 pandemic, nurses know that the dramatic racial and socio-economic inequities in suffering and death that have made the news are not new phenomena in US health care. The tenuous balance among profitability, productivity and patient safety has always created conflicts for nurses. The pandemic has unveiled to a larger audience both the failings and opportunities of the US health care system, and the ways in which capitalism harms the communities our institutions are supposed to serve. This paper draws upon the philosophies of social pathologies and power from Fromm, Foucault, and Deleuze and Guattari to offer a critical review of the functions of nurse leaders within a capitalist paradigm such as the US health care system, as well as a reflection on how nurses may subvert harm-causing structures and processes built into profit-motivated institutions.

This paper does not include original research and therefore does not have institutional review board oversight.

1.1 | Health care and capitalism

The impetus for profit chasing is a force that lies deep within the fabric of modern health care in the United States. Changes to health care operations and financing have been dramatic and frequent over the past 30 years, particularly with the introduction of the electronic medical record (EMR) (Sun et al., 2018). These changes are both the impetus for and the result of the continued corporatization of US health care, as hospitals and entire health systems evolve into extremely lucrative corporations. The United States spends 18% of its GDP or about $3.5 trillion on health expenses; over twice the average expenditure of other Western countries with post-industrial economies (Daniels et al., 2018). Despite spending more on health care than any other nation, the United States nonetheless has health outcomes inferior to those of other developed countries (Woolf & Aron, 2013). Commodification of health is a striking attribute of US health care, resulting in barriers for society's most marginalized persons/communities. The resulting corporatization of health care delivery distorts and inhibits the ways in which it is provided at every level of the system (Christensen, 2017). Capitalism's influence over health care acts as a pathogen through many vectors, including inequity and poverty, harmful products and poor resource allocation, and inequitable location and access to services (Sell & Williams, 2020). There are a multitude of salient examples of capitalism's influence and harm: treatment barriers that arise secondary to pharmaceutical price gouging (Houston et al., 2016); persistence of increased length of stay, complications, readmissions, charges and mortality among very low income patients receiving the US federal health coverage called Medicaid (Sastow et al., 2019); high rates of morbidity and mortality for Black patients (Rangrass et al., 2014); and more, the current devastating disproportionate death rates of COVID-19 (Yancy, 2020) and disparate resource allocation of COVID-19 vaccination to marginalized communities (Jean-Jacques & Bauchner, 2021). The persistence of these examples indicates that lessons have not yet been learned.

1.2 | The commodification of health care

In a commodity driven market, hospital performance is measured largely by efficiency and profitability (Buchner et al., 2016). Treatment and resource provision agendas are thus inextricably linked to profit. There is constant pressure to compete for market share and decrease spending on programmes that have low or no insurance reimbursement—the latter are often programmes that support the health and well-being of the most vulnerable in the community. A capitalist economy employs market incentives that reward self-interested behaviour and contradict the ethical requirements of nursing practice (American Nurses Association [ANA], 2017; Sell & Williams, 2020). Hospitals' profit-motivated practices have been directly linked to higher morbidity and mortality (Cohen, 2020). Costly investments in seductive technologies and concierge services to attract well-paying patients, using data and negotiating payer contracts to attract healthier patients, and exploitation of specialist expertise to increase volume of high dollar procedures are all cornerstones of the profit-driven health care model (Glied & Sacarny, 2018). This system also has a perpetual focus on reduction in health care's largest cost: nursing labour (Yakusheva et al., 2020). Evidence from the United States suggests that more nursing hours are associated with better outcomes for hospitalized patients, including decreased rates of failure to rescue. Despite this, enhancements to nurse staffing processes remain insignificant in part due to perceptions that these are prohibitive for hospitals wishing to remain profitable (Everhart et al., 2013).

Philosopher Erich Fromm wrote extensively about the ways in which capitalist-oriented frameworks are driven to create leaders who serve its needs: large numbers who cooperate without resistance, are not contemplatively subject to principles of conscience, and who are 'willing to be commanded to do what is expected of them, to fit into the social machine without friction' (Fromm, 1981, p. 57). While the proliferation of profit ideals is deeply concerning, more problematic is the widespread characterization of values that are integral to the nursing profession as errant ideals and opinions that seem impossible to achieve. In his commentary on the corporatization of the university, Oakeshott (1965) said, 'It is a very powerful world; it is wealthy, interfering and well-meaning. But it is not remarkably self-critical; it is apt to mistake itself for the whole world, and with amiable carelessness it assumes that whatever does not contribute to its own purposes is somewhat errant' (p. 65). Prioritizing corporate profits runs in opposition to improving access to quality care for those most marginalized (Matcha, 2000). This divergence means that the most basic of goals (the hungry have food, the homeless have shelter and safety, one should not have to choose between food and medication, etc.), are quickly seen as exceedingly difficult to achieve in a capitalist foundation. Nurses must then forego opportunities to realize professional potentialities in service of a system that preferentially capitalizes on inequity and oppression. To preserve positions of authority, the capitalist and bureaucratic natures of health care have turned nurse leaders from educated advocates for health and well-being into objects, managing other objects. Fromm explains:

> Aside from the industrial bureaucracy, the vast majority of the population is administered by still other bureaucracies … All these bureaucracies have no plan, and no vision … When man [sic] is transformed into a thing and managed like a thing, his managers themselves become things; and things have no will, no vision, no plan. With the bureaucratic management of people, the democratic process becomes transformed into a ritual … the individual has lost almost all influence to determine decisions and to participate actively in the making of decisions (Fromm, 1981, p. 48).

2 | CORPORATE BUZZWORDS

The ostensible shared beliefs of a health care organisation are most often found in its published statements of mission, vision and values.

Although the specific words may vary, most such statements express similar objectives, aspirations and assumptions: generally, to improve health, to demonstrate commitment to excellence, quality and so forth. Taking up these values is often at odds with the lived reality of purported excellence via metrics, and rather than questioning the system's frameworks, nursing instead looks internally for ways to 'fix' the lack of congruence between its obligations to patients and alignment with corporate health care culture. Perhaps most notoriously, the concept of 'evidence-based practice' has afforded this culture numerous opportunities to silence and restrict innovations in nursing science and practice.

> It is asserted that if, somehow, nurses could identify what constitutes evidence of best practices, then patient "outcomes" would improve … But nurses run the risk of being caught up in a meta-narrative in which empirical evidence of best practice becomes a walled-off space of isolation. The space of isolation … can rapidly become a site of violence if it lacks the shared conviction that compassion is not just a sufficient but absolutely necessary component of nursing practice (Browne & Reimer-Kirkham, 2014, p. 60).

It is thus clear that the ostensibly nursing-oriented ideas of 'evidence-based-practice', 'quality' and 'patient-centred-care' have been disempowered and reduced to feeble tropes and buzzwords used to justify, and fit into, a health care structure that empirically works in opposition to the values and obligations of the nursing profession. Without advocacy to tangibly operationalize these nursing concepts in equitable and meaningful ways *beyond* and *despite* the profit motive of the corporation, they are no more than feeble justifications of existence at the leadership table; poor examples of a collective choice to ignore the true power nurses have over life and death. Although institutional promises of 'excellence' and 'best practice' are seductive (Gentles et al., 2015), the nurse leader's distancing from shallow statements not backed by results is necessary as a means to preserve both the self and the integrity of the profession. Following blindly and silently the decisions of those who centre profit motives leads to the harm of our community (Fromm, 1981).

This begs the question: Are nurses, particularly those in leadership, advocates for those to whom the profession aims to bring health and relief of suffering, or are nurse leaders positioned as passive cogs (things) in a capitalist machine (managing things)? Deleuze and Guattari call this the 'despotic-(State)-machine' (DsM): that which brings together all the state components (*dispositifs* or apparatuses) necessary for repression and control. The DsM is repressive in that it creates a rigid state apparatus (the capitalist health care system) that results in suffering for the many Americans unable to afford health care. In effect, machinic enslavement occurs when assembled persons, 'social relations and desires, known in Deleuzian theory as "machines"', are rendered subordinate to the regulatory function of the DsM and are 'hence incorporated in an overarching totality' (Robinson, 2010, p. 4). This mega-state-machine serves to negatively impact horizontal connections (caring practices) while increasing the intensity of vertical subordination created by hierarchical and authoritative structures (Robinson, 2010). On the margins of this rigid and encompassing mega-machine, there are spaces of freedom that nurses should occupy in order to resist this capitalist machine: These are the spaces of compassion. Georges (2014) describes that the failure to effectively occupy and safeguard this space through upholding the potentiality of humanity puts us at dire risk of the *Unspeakable* in nursing; 'the creation/maintenance of biopolitical spaces in which compassion—for oneself and one's patients—is rendered severely diminished to nearly impossible' (p. 60).

Given the state of the capitalist profit-driven health care structure, and nurses' role in upholding its harm causing scaffold, it is clear that the profession has managed to stray from the belief that the ultimate value in all social and economic arrangements of humanity (and nursing) is to create conditions in which a human attains their full potentiality (Fromm, 1981). We erroneously see ourselves as beholden to the institutions in which we are employed, that we are required mainly to *nurse* institutions rather than people (Dillard-Wright et al., 2020, p. 139). In a profession demonstrating moral aptitude and maturity, the identification and healing of social injustice is an ethical requirement, prioritized over superficial loyalty to organisation and political power, and it is therefore the responsibility of nurse leaders to hold the profession accountable as such (Lavoie et al., 2006). Fromm (1981) asserts that obedience to an institution, including one exerting harm, is an act of submission to its values and an acceptance of a foreign will or judgment in place of one's own. In following Fromm's assertion, a nurse leader's obedience to one's own reasoning or conviction is an act of affirmation. Which set of values does the nurse leader choose to affirm? The centring of capitalism over actualized humanity is evidence of our profession's dangerous shortfall in reckoning with the structures of imperialism, colonialism, and racism, and limits the integrity and reality of an emancipatory praxis. The social contract between nurse and patient has been broken.

3 | SUBVERSION AND *PARRHÈSIA*

3.1 | Operationalizing subversion

Although a common definition of subversion is to 'destroy and overthrow', the Latin roots of the word suggest a meaning of 'to turn from below' (Merriam-Webster, 2020). For nurse leaders, the aim of subversion is perhaps not to work entirely against missions of corporate profit, but rather to 'work in parallel to it by subverting its purpose and adding value(s) to its product' (Rolfe, 2013, p. 52). Because nurse leaders are paid and employed by corporate health care institutions, there is an obligation to work towards the financial success and achieve the goals of 'excellence' that sustain corporate US health care structures. At the same time, as nurses, we have a parallel obligation to do so in ways that centre the patient and community and to add humanistic as well as financial value. Nurses in leadership hold positions of influence and power that can, or should, directly affect the

priorities and decisions surrounding care delivery and resource allocation—but the inescapable reality is that the financial soundness of a health care institution is more often the priority as it is the foundation upon which the very existence of corporate health care stands. It is, however, important to acknowledge how and where this priority guides decision making.

3.1.1 | Subversion through thought

The first step to subverting the structures that harm patients and communities is a commitment to critical thought. Participating in contemplative thought and discourse is a critical obligation of any nurse holding a position of leadership. For if one reflects, even briefly, on the professional ethical obligations of nursing (even as simply written in the ANA Code of Ethics), one would quickly find a stark difference in ethical roles and responsibility versus 'job duties'. There are well-documented examples in which institutions facilitate nursing practice that abandons compassion, human dignity and justice (Thorne, 2014). For a nurse leader to tolerate, and even advocate, for a health care system that perpetuates systematic oppression of the most vulnerable among us begs the question of whether title of 'nurse' applies in these positions of leadership at all.

Despite a high level of nursing education, nurse leaders too often forego critical opportunities to assert leadership of our profession, lacking the conviction necessary to maintain a consciousness of others' suffering and a desire to alleviate distress (Georges, 2014). The thinking has been split from the feeling; the feeling that our very actions and thoughts have a direct and palpable impact on the quality of life, if not survival, of people. Nurse leaders within the hospital have largely failed to offer sustained reflexive critique of the ethics of institutional operational practices, nor have we tangibly and broadly adjusted our practices based on the critiques of notable nurse ethicists (Collen Varcoe, Jill White, Sally Thorne, etc.). This has left the US health care system bereft of any critical regulating influence by nurse leaders within the hospital. This paucity of critical thought has allowed administrators and bureaucrats to perpetuate corporatization of health care in the name of excellence and efficiency. It could be that the aversion to reflexive thought about nurses' roles and obligations before all else is due to the fact that *thinking* about the divide in purpose and practice for nurses in this health care system, and the specific obligation of leaders, is tantamount to acknowledging its existence and moreover, one's own complicity in its sustenance. As Russel explained:

> Men [sic] fear thought more than they fear anything else on earth—more than ruin, more even than death. Thought is subversive and revolutionary, destructive and terrible; thought is merciless to privilege, established institutions, and comfortable habits … It is fear that holds men [sic] back—fear lest their cherished beliefs should prove delusions, fear lest the institutions by which they live should prove harmful, fear lest they themselves should prove less worthy of respect than

they have supposed themselves to be (Russell, 1916, pp. 178–179).

Although honest reflection and dialogue on this chasm between purpose and praxis is deeply challenging and palpably discomfiting, in following Russell's philosophy, the capacity to disobey and participate in radical thought and discourse is not based on principle or conflict for conflict's sake but on a deep love for life and belief in the actualizing capacity of human beings. To move beyond the tyranny of the present, we must iteratively interrogate our self-representations. Asking ourselves and one another: 'Did I bring into play those principles of behavior I know very well, but, as it sometimes happens, I do not always conform to or always apply? Am I able to adhere to the principles I am familiar with, I agree with, and which I practice most of the time?' (Foucault, 2001, p. 165). Critical thinking in bedside nursing requires that nurses question policies, practices and interventions that pose either potential problems or benefits for patient care. Nurse leaders, too, must be good critical thinkers and must be held accountable for their participation, or lack thereof, in the active interrogation and challenging of well-documented oppression of populations (Perron et al., 2014). We cannot allow structures of education and power to drum out the impulse for compassion, and we must resist assimilation to a violent system by critically thinking about how we are positioned within these institutions. This action is the only appropriate response to a system that marginalizes whole groups and strips them of power (Perron et al., 2014).

3.1.2 | Subversion through parrhèsia

> When you accept the parrhesiastic game in which your own life is exposed, you are taking up a specific relationship to yourself: you risk death to tell the truth instead of reposing the security of a life where the truth goes unspoken … But the parrhesiastes primarily chooses a specific relationship to himself: he prefers himself as a truth-teller rather than as a living being who is false to himself (Foucault, 2001, p. 17).

Truth speaking is daring, even revolutionary. Foucault (2001) defines the risk-taking truth teller using the Greek word *parrhesiastes*; one who is courageous and says something dangerous—different from what the majority find comfort in saying—and demands that truth be spoken despite the risk of losing privilege. The parrhesiast cleaves to a truth acquired through experience and the development of a unique *knowing* (Carper, 1978), and must therefore share this truth at risk of disrupting a powerful establishment (Perron et al., 2014). The parrhèsia does not simply speak the truth or teach others but directly critiques the status quo, as to say that 'this is what we have done, and are wrong in so doing' (Fromm, 1981). The truth speaking makes visible the discrepancies between statements and actions. Foucault (2001) describes this as:

A kind of verbal activity where the speaker has a specific relation to truth through frankness, a certain relationship to his own life through danger, a certain type of relation to himself or other people through criticism (self-criticism or criticism of other people), and a specific relation to moral law through freedom and duty (p. 19).

A frequently voiced axiom in nursing leadership and education is the imperative that nurses must learn to speak finance. It has been asserted that if nurses are to *deserve* a seat at the strategic leadership table and desire to remain influential advocates, removing the emotion from the budget process is essential (Muller & Karsten, 2012). This is a suspect statement even on its face, given that over 85% of the nursing workforce is made up of women—long castigated as being the over-emotional, nurturing and caring members of society (Burton, 2020). And although it is undeniable that nursing leadership must *speak* finance, more critical is that through the financing process, nurse leaders learn to speak nursing *to* finance. A health care institution's budget reflects its leadership's consensus on priorities and clearly delineates what issues, opportunities and people are most important. Removing the emotion—the human reaction—from the impact such decisions make removes the nursing perspective from the conversation. When nurses take a seat at the strategic table, they must become experts at holding space for the emotion of the human impact of the financial decisions of an institution.

Veracity, or truth telling, is one of the core moral obligations identified in the nursing code of ethics, and nurse leaders have the unique opportunity, platform and obligation to speak truth on behalf of those in our care: nurses, patients and communities (ANA, 2016). The personal, aesthetic and ethical knowing of nurses critically positions the nurse to speak from a place that has touched and felt the depths of the human experience (Carper, 1978), and this is the type of *knowing* that lends itself to parrhèsia. It is all but certain that nearly every nurse leader has sat with practitioners of other disciplines, sometimes as the only nurse, with a tongue burning to speak against decisions detrimental to the profession, or to the safety of patients. And many of us equally recall painfully swallowing that hot coal of truth and advocacy, for fear of ostracization, retribution or retaliation. Participating in parrhèsia creates dissonance between oneself and an institution of power, and the risks of isolation, alienation and even retaliation are all too real.

What then, if nurse leaders viewed truth telling in the face of danger as a duty? The parrhèsia uses voice to maintain a sense of individualized identity; something that the over-regulated, over-monitored, and over-governed profession of nursing has long struggled to articulate and solidify. As opposed to existing as extensions of institutional identity and patient agency and parroting organisation slogans:

> … nurses could regain a sense of their own agency that is robust in contexts of managerialism, technocracy, bureaucratization, research orthodoxy, health

consumerism, anti-intellectualism, and the proliferation of medical-industrial-academic complexes (Perron et al., 2014, p. 48).

4 | CONCLUSION

The nurse leader can act as a parrhèsia in viewing truth telling as a duty critical to improving and indeed to saving the lives of patients. Ramifications of the decisions by those in power have even greater impact in institutions that serve those with little to no political agency, those not protected by social norms: immigrants, those detained or incarcerated, people with mental illness and so forth. The nurse leader has a freedom and a platform that their patients, particularly the most oppressed, do not, and must take the courageous risk of choosing 'frankness instead of persuasion, truth instead of falsehood or silence, the risk of death instead of life and security, criticism instead of flattery, and moral duty instead of self-interest and moral apathy' (Foucault, 2001, pp. 19–20). This act itself hinges upon the ability to welcome and sit in the discomfort of imbalance as opposed to appeasing and reinforcing existing power structures. There are worse things than being uncomfortable, and the true nurse leader knows that being comfortable, safe, conforming and liked is no option when the people to whom we are obligated suffer and die under our blanket of silence. Holding a leadership position gives one power, and having power over someone or something includes the power of life and death (Agamben, 1995).

5 | IMPLICATIONS FOR NURSING MANAGEMENT

We appeal to every nurse leader to feel deeply the responsibility of their role and that of the nurses in their charge; to think thoughtfully and deeply about the identity and ethical obligations of our profession, and the ways it may or may not align with the 'job' we do each day. We must consider our patients, our communities, our country and the health and care we are or are not promoting. We acknowledge the risk and dangers of taking such action and assert the power that lies in nurse leaders forming alliances to safely participate in emancipatory dialogue. In these group processes, we discover a therapeutic enlightening and an emancipation amelioration of the human condition (Jacobs et al., 2005). We sit today in the midst of a pandemic that has destabilized the overall health system and brought to light the harshest of realities in which we operate. Do we choose to go back to the way things were, or will we choose to use this destabilization to build a system that is true to our profession, ourselves, and our patients? We will answer these questions each day in how we treat our staff, speak up in meetings, build our budgets, write our policies and indeed in how we think.

> Many will say that people do not want ideals, that they do not want to go beyond the frame of reference in

which they live .... On the contrary, people have a deep longing for something they can work for and have faith in. Man's whole vitality depends on the fact that he transcends the routine part of his existence, that he strives for the fulfillment of a vision which is not impossible to realize—even though it has not yet been achieved (Fromm, 1981, p. 90).

CONFLICT OF INTEREST

This manuscript does not include original research. This work received no external funding, and no conflict of interest has been declared by the authors.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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