Review Paper

Diminished Role Autonomy and Ambivalence, Key Factors in the Demise of Person-centred Care

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ABSTRACT

Background: The nursing workforce has been under prolonged strain, beginning with the pandemic and continuing into a post-pandemic inflationary economic crisis. Research published in 2017 in Australia identified registered nurse practice to be person-centred. This practice is embedded as a foundational concept in the Australian Registered Nurse standards for practice, and it was determined to represent actual, rather than aspirational practice at the time of the underpinning research.

Results: This critical paper examines whether the practice has shifted to a biomedical or system-centred model of nursing care in response to sustained stress.

Conclusion: The practice appears to have shifted to a biomedical or system-centered model of nursing care. This shift has not been a consciously decided upon course of action, but rather a regression to an older vision of nursing. The reinvigoration of bureaucratic hierarchical models of care, which impinge on role autonomy, is conceived as a mechanism of the shift, arising through ambivalence.

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Highlights

- There seems to be a shift away from person-centred care.
- A regression to a bio-focused model may have occurred, contributed to by the pandemic and financial crisis.
- Role autonomy and ambivalence are two factors worthy of further research.

Plain Language Summary

A robust research project identified that registered nurse care was person-centred in Australia in 2017. The concept of person-centeredness became a foundational component of the Registered Nurse standards for practice. Research in Australia and internationally has identified that person-centred care is not the norm. It appears plausible that the pandemic and financial strains in the interim period have contributed to reduced role autonomy, increased ambivalence, and a regression to a bio-focused, task-driven model of care. Further rigorous research is indicated.

Introduction

In Australia, person-centred care is a central principle embedded in the Nursing and Midwifery Board standards for practice for registered nurses and nurse practitioners (Nursing and Midwifery Board of Australia (NMBA), 2016; NMBA, 2021). Person-centred care, as a concept, has evolved in nursing internationally, alongside the principles of holistic care and praxis, where nurse education, research, and practice are closely linked. The registered nurse is conceived as a reflective practitioner engaged in lifelong learning, who thinks critically and provides person-centred care. The World Health Organization (WHO) produced a policy framework in 2007 titled people-centred health care: A policy framework (WHO, 2007) and has continued to refer to integrated care centred on people as a primary objective (WHO, 2023). The International Council of Nurses (ICN) has adopted person-centred care as a strategic priority and the philosophical basis of nursing (ICN, 2023). Yet, it is clear that, at least during the COVID-19 pandemic, nurses have changed the way they practice (Clari et al., 2021). The sustained strain on the nursing workforce over the past few years has had a significant impact, as evidenced by increased burnout and major workforce challenges (Mannix, 2021). This strain raises the question of whether the view of the registered nurse as being engaged in person-centred care remains contemporary or has it slipped to an aspirational status.

A large-scale, federally funded national project identified that nursing care in Australia was person-centred in 2017 (Cashin et al., 2017). International research published since that time is critiqued to determine whether the case can be made that nursing care remains person-centred. The factors of role autonomy and ambivalence are presented and critically assessed as two plausible factors that have constrained person-centred care and contributed to a lack of awareness of the shift to system-focused care that appears to have occurred.

Person-centred Care

In Australia, the NMBA defines person-centred care in the Registered Nurse Standards for practice as follows:

"Person-centred practice is a collaborative and respectful partnership built on mutual trust and understanding, facilitated through effective communication and interaction. Each person is treated as an individual, respecting their ownership of health information, rights, and preferences while protecting their dignity and empowering their choices. Person-centred practice recognizes the role of family and community concerning cultural and religious diversity (NMBA, 2016,).

Person-centred practice places the person at the centre of care. At the time of the multi-methods research study undertaken to underpin the development of these standards, person-centred care was identified as common practice in Australia (Cashin et al., 2017). Over the 8 years since the research was conducted, reductions in university funding, a global pandemic, and an economic crisis have occurred.

Workforce shortages of health workers, including registered nurses, have been widely reported (Mannix, 2021). The WHO forecasts a global shortfall of 10 million health workers by 2030 (WHO, 2023). The shortage of registered nurses has been attributed to the aging of the workforce, reduced student intakes, investment in the profession, and burnout following the COVID-19 pandemic. The international population of registered nurses is also highly mobile, exacerbating shortages in countries where lower wages are paid. During and after the COVID-19 pandemic, registered nurses reported engaging less in ongoing education, specifically continuing professional development (Pracilio et al., 2023). This international context highlights the question of whether, under these stressors, registered nurse care has remained person-centred.

Research related to person-centred care over the last 8 years is scant. It largely focuses on person-centred interventions and self-reported facilitators and barriers to practicing in a person-centred way. For instance, a scoping review identified that the most prominent research related to person-centered care is based on evaluation of the person-centred nursing framework developed by McCormack and McCance, or other interventions aimed to promote this care, alongside barriers and enablers to the expression of person-centred care in contexts where nursing is practiced (Ryan, 2022). Notably, the research considered in the review was largely outdated, with many citations dating back over 10 years. An ethnographic study in the Netherlands, which focused on the exploration of fundamental care in three inpatient units, identified that nurses rarely prioritized person-centred care, instead focusing on physical biomedical tasks (Belle et al., 2019). The study's context, only to a single hospital site, was a limitation. In a case study of the nurse navigator role in Australia, it was found that person-centred care is hindered by a siloed approach to care and a system-focused approach (Byrne, 2021). In two intensive care units in Australia, Jakimowicz (2018) conducted a grounded theory study, identifying a tension between person-centred care and a focus on biomedical clinical skills as the primary focus that commonly prevails. In an adult in patient mental health unit, also in Australia, through 12 interviews with patients, it was found that the purpose of collaboration had not been explained and was not clear and that while nurses were viewed as been allied in recovery their workload was seen to be a barrier to this and goals were not checked in on through admission (Reid et al., 2018).

In the United Kingdom, after interviewing 26 nurse clinicians, Entwistle et al. (2018) identified tensions in delivering person-centred care and an awareness of falling short in the delivery of this care. In Sweden, Forsgren and Björkman (2021) identified, in the context of an evaluation of a pilot person-centred intervention in a hospital outpatient setting, through an analysis of 17 nurse-patient interactions, that nurses took an authoritative deontic position when discussing self-management goals. This outcome was discussed as not being consistent with person-centred care. This study was limited by its single-site context. In South Korea, when exploring patient safety, Hwang et al. (2019) conducted a cross-sectional study of 479 nurses from two general hospitals. They identified a correlation between patient participation in safety activities and patient-centred care. However, they also reported that patient involvement in safety activities was low. This relationship implies that person-centred care was also low. Additionally, in South Korea, Kong et al. (2022) identified through interviews with 24 staff members from 6 nursing homes that insufficient resources, a lack of education, a negative mindset among nurses towards patients, and poor relationships between nurses, residents, and families were barriers to person-centred care delivery.

In the Republic of Ireland, Jackman-Galvin and Partridge (2022) conducted a phenomenological study within the context of residential services for people with intellectual disabilities, identifying challenges to delivering person-centred care through the perspectives of participants. The study emphasized a perception of a lack of support, funding, time, and training to provide optimum care. An Australian national survey found a low rate of registered nurses' knowledge about making reasonable adjustments—a central feature of person-centred care—for their neurodiverse patients (Wilson et al., 2022). In Finland, a survey of 200 nurses from 6 long-term residential facilities found some indication that further training and supervision on person-centeredness was needed (Pakkonen et al., 2023). In a study of barriers to person-centred care in Pakistan that utilised interviews with 19 nurses across two hospitals, several key themes emerged as barriers to person-centred care. The themes included education, communication skills, the inferior status of nurses, the lack of respect nurses receive from patients, workload, and nurse-physician conflict (Younas et al., 2023).

Although heavily biased towards self-report, through interviews or questionnaires, and limited to single or a small number of sites, the international study findings have provided insight that biomedical-focused, or system-focused, registered nurse care appears more common than person-centred care. Where implemented, person-centred care faces many challenges/barriers and is not the dominant mode of care delivery. Observational studies are lacking, but are indicated to determine if registered nurse care is indeed person-centred. While workload and resources appeared, as hypothesised in the current context as barriers, work culture (Chenoweth et al., 208) and transformational leadership (Lindner et al., 2023; Rutten et al., 2021) appeared from interviews and questionnaires in Australia, Sweden and Demark as significant factors enabling person -centred care. This finding is consistent with that of Younas et al. (2022) in Pakistan, which highlights the inferior status of nurses —a trend that appears to be becoming increasingly prevalent internationally —and is identified as a barrier.

It is plausible that the factors of role autonomy, as fostered through transformational leadership or constrained in other styles of leadership and workplace culture, and ambivalence are worthy of consideration as key factors related to a shift from person-centered to system-focused care. These factors may have hindered a positive adaptation to the internationally experienced workforce stressors during and after the pandemic. The situation, as it has evolved, appears to include the demise of person-centered care.

Reasonable adjustments: A person-centred practice exemplar

Reasonable adjustments to practice, while a term specific to care of neurodiverse populations, when applied, are a good example of person-centred care. The barriers to healthcare access and poor health outcomes experienced by the neurodiverse population are well documented (Cashin et al., 2018; Lewis et al., 2017; Walsh et al., 2020). People with intellectual disability and or autism have longer hospital stays and are readmitted more frequently than the typically developing population (Trollor et al., 2017). The United Nations convention on the rights of persons with disabilities places the onus on signatory states to provide the highest possible level of healthcare, which involves providing reasonable adjustments to prevent discrimination (United Nations, 2006). Adjustments can involve organisational changes aimed at the physical and cultural environments of care, as well as individual adjustments such as those to communication and routine (Kersten et al., 2023; Moloney et al., 2021). In the largest study of this kind, it was acknowledged that Australian registered nurses' familiarity with the concept of reasonable adjustments was low. Yet, their self-report implementation of adjustments was higher (Wilson et al., 2022). The survey was conducted at the start of the pandemic, and it was hypothesized that, as self-reported making of adjustments occurred at a rate greater than familiarity with the concept and theory of reasonable adjustments to practice, the provision of person-centred care may still have been at play, albeit within the minority of respondents. This study may have indirectly measured the shifting axis as it was occurring. It is hypothesized that knowledge would remain low, and at this point, even fewer adjustments to practice would be reported if the survey were replicated.

Role autonomy

The positive relationship between nursing role autonomy and improved job and patient outcomes is apparent in the literature. For individual nurses, greater levels of perceived role autonomy have correlated with employee retention, safer practices, and job satisfaction (Basaran Acil & Dinc, 2017; Pursio et al., 2023). Regarding patient outcomes, higher role autonomy for nurses has been associated with lower patient mortality rates and improved health outcomes (Rouhi-Balasi et al., 2020; van Oostveen & Vermeulen, 2017). Additionally, higher levels of role autonomy for nurses contributed to lower healthcare costs and increased safety (Pursio et al., 2023). The explicit link between levels of nursing role autonomy and person-centered care remains to be explored. As mentioned earlier, insufficient funding, time, and other resources were commonly identified in international research as existing barriers to person-centred care delivery. These factors increased in prominence during the pandemic as demand for health services overwhelmed available resources and have continued in the climate of fiscal restraint following the post-pandemic inflationary financial crisis.

The pandemic put pressure on the health system. Nurses at the front lines of care were often asked to work extra hours and deployed across healthcare systems to prevent failures in the system's ability to provide access to care. Nurses experienced higher rates of burnout and absenteeism related to illness and fatigue. Studies have identified the strong impact of the pandemic as a factor that affected education, burnout, staff turnover, and the experience of additional stressors (Catania et al., 2021; Desroches et al., 2022; Haas et al., 2020; Krzyzaniak et al., 2021; Labrague et al., 2022; Moore et al., 2021; Ryder et al., 2022).

Nurses have traditionally prided themselves on keeping health systems functioning, even at times with makeshift measures, often colloquially referred to as "blue tack and elastic bands." As part of maintaining operational systems, the focus of nursing care likely shifted to system-centered care, and leadership potentially reverted to a hierarchical, authoritative nature consistent with nursing's past. This trend is antithetical to the identified enabling transformational leadership that facilitates person-centred care. In society in general, a trend toward proformalism was noted to have strongly emerged during the pandemic. This term, coined by Salvatore Babones, refers to an obsession with ticking boxes without investing thought in the outcome of the box-ticking or the meaning behind it (Babones, 2020). As system maintenance, including patient throughput, evolved as the primary focus of care, it is plausible that person-centred care was displaced, which has a relationship to the declining role autonomy experienced in a paramilitary style of nursing leadership. In transformational leadership, the aim is to inspire individual growth through innovation and adaptation, as opposed to a leadership style focused on compliance with rigid policies and protocols (Rafferty et al., 2023).

Education deficits were noted as barriers to person-centred care. During the pandemic, income generated by universities was curtailed in many countries due to restrictions on international student mobility. It decreased domestic student participation as courses migrated online. This decline in income in many contexts led to a decrease in investment in courses. The trend of local health districts (hospitals and community services) providing education support to students on placement, and being paid to provide clinical facilitation, as opposed to university-employed educators providing clinical education while on placement, has intensified. This may mean that students are socialized into the culture of authoritarian leadership and system-focused care, with associated reduced role autonomy, from a very early stage in the learning experience. Such trends may palusibiliy exacerbate the education deficits identified in the research related to reasonable adjustments to practice. Breaking this socialisation was one of the aims of transitioning from hospital-based schools of nursing under an apprenticeship model to university education. University education was intended to foster critical thinking and a principle-based approach to adapting nursing practice, as opposed to mere compliance.

Ambivalence

Ambivalence provides a lens for understanding registered nurses' attitudes toward the focus of care and the shift from person-centered to system-focused, biomedical-driven care without correction. In the study of attitudes, there has been a shift away from the rigid nature of bipolarity and a highlighting of the notion of ambivalence (McGrane, 2019). Traditionally, attitudes were measured across dichotomous scales, ranging from extremely positive to extremely negative views on a topic, with the middle of the scale indicating neutrality or no strong view (Thompson et al., 1995). Such an understanding of individual attitudes overlooks the concept of ambivalence, where an individual can simultaneously hold both positive and negative views on a topic (Cacioppo et al., 1997; Thompson et al., 1995). In psychology, the core of ambivalence lies in a conflict between an individual's cognitions, emotions, and motivations (Luescher & Pillemer, 1998). This conflict and discomfort between positive and negative views, embodied in feelings of ambivalence, can contribute to cognitive dissonance (Festinger, 1957). Cognitive dissonance is uncomfortable and pushes towards reconciliation of feelings and clarification of thinking. This discomfort, in theory, drives adaptation.

The sociological perspective related to ambivalence allows an understanding of when ambivalence is not a force towards adaptation. Unless surfaced and critically reflected upon, ambivalence can act in the background in an insidious manner indefinitely. This ambivalence can shape behaviours without any level of awareness of what it is that is shaping the behaviour:

"Submerged in reality, the oppressed cannot perceive clearly the 'order' which serves the interests of the oppressors whose image they have internalised. Chafing under the restriction of this order, they often manifest a type of horizontal violence, striking out at their own comrades for the pettiest of reasons" (Freire, 1972, p. 38)."

Discussion of nursing as an oppressed profession, with medicine serving as the internalized oppressor, is hardly novel. In the context of nursing as an oppressed profession, the internalised oppressor is medicine and the medical model. "The concrete situation of oppression, which dualizes the 'I' of the oppressed person, thereby making him (sic) ambiguous, emotionally unstable, and fearful of freedom—facilitates the divisive action of the dominator by hindering the unifying action indispensable to liberation" (Freire, 1972, p. 140). In nursing, this manifests as nurses being subservient to medicine and the

system, with an assistive role. This assistive role is consistent with the plane analogy invoked by McMahon and Pearson (1991) in the preface to their book, Nursing as Therapy, in which nurses are framed as flight attendants. The flight attendants make passengers comfortable but are dispensable. The cockpit crew consist of medical practitioners as the pilots and allied health practitioners as the other cockpit staff who have indispensable role in flying the plane and getting from point A to point B (McMahon & Pearson, 1991).

The experienced existential duality of the internalized oppressor and the modern view of nursing can lead to the establishment of bureaucracies and the adoption of proformalism, which undermines the modern nursing identity. "In turn, this violently repressive bureaucratic power can be explained by what Althusser calls the reactivation of old elements in the new society each time special circumstances permit" (Freire, 1972, p.128). The special circumstances that have led to a retreat from a medical model and a rigid hierarchical bureaucracy in this case may have been the stressors of the pandemic and the post-pandemic period. This phenomenon has previously been observed in Australia. One example is the special circumstance of the introduction of the role of Nurse Practitioner in the Australian context, a role with greater autonomy, and the bureaucratically created counter role of clinical initiative nurse, a protocol driven role that incorporated a high level of medical permission granting, that negated the need to employ nurse practitioners. A role created and championed by nurse managers in the absence of any evidence (Cashin et al., 2007).

The stressors of the pandemic and post-pandemic period have tilted the axis or altered the frame from person-centered care to a biomedical or system-centered model. As the oppressor was internalised, this shift, unless surfaced in critical reflection, may not be noticed by those immersed in practice. Goffman posited the term "frame space" as a more precise way to conceive of norms (Kendon, 1988). The frame space, or the way nursing care is framed and enacted, is subtly altered through normative changes to practice instituted by the aforementioned bureaucracies within nursing and other policy-making institutions. What is accepted as within the nursing main line, or storyline track, and what constitutes core business, is framed within social interaction as directed by the revitalized bureaucracies and bureaucrats (Kendon, 1988). As these norms shift without notice, nurses do not experience the discomfort typically associated with cognitive dissonance. Without discomfort, there is no drive to reflection and adaptation in the form of consciously reconciling beliefs and actions.

A small number of single-site nursing studies have explored nursing ambivalence towards certain care practices, such as the use of early warning scores (Mølgaard et al., 2022), dual relationships within mental health care (Unhjem & Hem, 2025), and caring for patients at the end of life (Tiedtke et al., 2018). In a study of 28 Chinese nursing students in Australia, Zhou et al. (2010) identified feelings of ambivalence regarding cultural and social differences, the disparity between expectations of Australia and reality, and the conflict surrounding the decision to stay or return to China. These studies were largely qualitative and did not utilise a validated measure to determine ambivalence levels. All studies, except for Zhou et al. (2010), conceptualized ambivalence through a psychological lens, as opposed to utilizing the insights generated through a sociological frame. Zhou et al. (2010) did not consider the perspective of the philosopher Paulo Freire on ambivalence; however, they did consider dichotomies in social behavior and the strain of attempting to achieve both poles, drawing on the work of sociologist Neil Smelser. The sociological frame enables an understanding of the insidious change in norms without necessarily causing cognitive discomfort and therefore a drive to correct the tilt of the axis. It also, when considered in full, allows an understanding to emerge of the dichotomies between person-centred and biomedical or system-centred care.

Conclusion

Eight years ago, a large-scale observational study and self-report surveys with very high response rates identified that person-centred care was the primary focus of Australian registered nurse practice, and this was subsequently embedded in the NMBA registered nurse standards for practice. Since that time, registered nurses have personed the frontline in healthcare during a global pandemic and continued their practice without pause through the post-pandemic inflationary financial crisis. The cited international research has identified a shift in norms towards more biomedical or system-focused care. This shift is not widely discussed in the literature and appears to have been largely overlooked. Ambivalence, while not widely discussed in the international nursing literature in recent times, from a sociological perspective, plausibly explains why the shift has occurred, how role autonomy has been restricted through the entrenchment of a rigid bureaucracy, and why the shift in frame has gone unnoticed. This paper is novel in surfacing the change in care and offering a referent through which sense-making can occur. Sense-making is the first step towards remediation. Future large-scale research is warranted to deter-

mine whether the dominant model of nursing care practiced internationally is person- or system-focused. Role autonomy and ambivalence are promising measures to utilise in future studies aimed at understanding nursing behaviour. This study is limited by the paucity of research in the domain of identifying whether nursing care is person-centred internationally and the impact of factors such as role autonomy and ambivalence on nursing practice.

Ethical Considerations

Compliance with ethical guidelines

There were no ethical considerations to be considered in this research.

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Authors' contributions

All authors contributed equally to the conception and design of the study, data collection and analysis, interpretation of the results, and drafting of the manuscript. Each author approved the final version of the manuscript for submission.

Conflict of interest

The authors declared no conflict of interest.

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