

A Foucauldian analysis on the professionalisation effort of nursing in Singapore

Jennifer Loke, Derek Coluquhoun, Kah Wai Lee

Abstract

Aim: A discussion using Foucault's genealogical analysis to explain the professionalisation effort of nursing in Singapore.

Background: Nursing in Singapore is strongly influenced by Western civilisation, however, the discipline may not have adopted similar responses to the world's nursing professionalisation agenda as led by the West. An explanation on the ways nursing is spoken of and practiced in Singapore provides insights to the effects on nursing development in the country.

Design: The discussion uses Foucault's genealogy of power to draw on the practices of clinical nursing and nursing education in Singapore in an attempt to uncover the unorthodox professionalisation effort.

Data Sources: The discussion is an outcome of a critical reflective observation made by the authors between 1993 and 2014. It is supported by related literature, critical debates amongst Singapore healthcare professionals, nurse lecturers and the Singapore locals.

Implications for Nursing: Time and effort vested in overcoming medico-political dominance, should be used in the pursuit of high quality nursing clinical knowledge and acumen. Specialised nursing knowledge and autonomous practice should adopt an explicit focus in its mission to achieve the common good which is in favour of the public interest.

Conclusions: While the hierarchical nursing structure was the foundation for professionalising nursing, nursing subservience was the gateway for advancing nursing in Singapore. Without generalising the positive effects of the power-relations in Singapore, nursing practice which reflected the 'subservience in females' and demonstrated respect for authority within a hierarchical system had evidently led to good quality nursing practices which serve as a strong foundation for nursing to secure professional recognition.

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Introduction

Nursing remains entangled in a struggle to become professionalised, albeit the global professionalising nursing effort (Gillet 2011, Henttonen et al. 2011). The discipline in Singapore was also regarded as a low class menial job meant for women from the lower socio-economic group (Lee 2005, Loke 2012). It was only in recent times, that the locals were more receptive to the idea of nursing as a professional career choice. This had not only been the case for male Singapore

citizens, but also, some first general degree holders. This is a remarkable achievement given the fact that Singapore is a status conscious society (Kau et al. 2004, Katz 2006) that has a British Colonial history which associates nursing with either untrained nuns or Indian convicts (Lee 1985, Lee 2005, Loke 2012). Singapore, in many ways is strongly influenced by Western civilization and nursing development is no exception to this (Loke 2012). However, responses to the professionalisation nursing agenda may not necessarily follow a Western view. Drawing examples from practice in clinical nursing and nursing education in Singapore, Foucault's genealogical analysis is used to explain the nursing professionalisation effort in the country. This discussion provides an explanation on the way nursing is spoken of and practiced in Singapore to provide insights

Key words:

Foucault's genealogical analysis, healthcare reform, hierarchical health structure, medico-political power and dominance, Singapore nursing education, professionalisation of nursing.

to the effects these had on nursing development in the country.

Background to Singapore Nursing Professionalisation Effort

Professionalising nursing efforts have been around for more than a century (Rutty 1998). Formal professionalising effort in Singapore began in 1949. Nursing registration was then introduced under the ordinance based on British rule, but was not formalised until the establishment of the Singapore Nursing Board (SNB) in 1975. The board has similar role functions as the United Kingdom Nursing and Midwifery Council (2010), the Canadian Nurse Association (2008) and the American Nurse Association (2011), that it regulates a set code of ethics and is responsible for nursing practice and the enactment of the Nurse and Midwives Act.

Consistent with the professionalising effort, the School of Nursing (SON) was set up in 1956. The aim was to characterise nurse training with a high standard. The School offered various curricula which led to individuals registering as midwives, enrolled nurses (ENs) and registered general nurses (RGNs). Midwives and ENs could advance and seek promotion to RGNs, who in turn could pursue specialised qualifications to practise with more autonomy as post-basic nurses. All in all, only individuals who corresponded to a high standard of requirement were permitted to practice nursing. Other than organisational strategies, individual professionalising effort was also evidenced in 1957 by the establishment of the Singapore Trained Nurses' Association. This was renamed as the Singapore Nurses Association (SNA) in 1990, a result of the strong desire to professionalise nursing, to emphasise the concept of nursing education rather than nurse training (SNA, 2011).

In so far, the attempts to professionalise Singapore nursing did not seem to differ from other parts of the world. The required essentials and expected altruistic nature of the discipline were viewed as key to achieving professionalisation (Friedson 1983, Maloney 1986, Richman 1987). In many cases, nurse professionalisation effort were the result of nurses' aspiration to achieve a higher status in society. Still it is a political

process (James and Willis 2001) that could not occur in an ideological vacuum. In Singapore, it was likely to have been influenced by discourse of the local patriarchal government. In other words, the Eastern/Asian culture about subservience of wives and obedience of children (Dalton and Ong 2005), the patriarchal household and the primacy of domestic responsibilities of women (Coe and Kelly 2002) that were emphasised in the Singapore government policies would have an influence on nursing development in the country. These allow Foucauldian genealogical analysis to be useful for explaining Singapore's nursing professionalisation effort.

Usefulness of Foucauldian Genealogical Analysis to Reveal the Professionalisation Effort

Foucault's (1977) primary concern in his work on Discipline and Punish was with an understanding of how power operates. This was through his examining of the development of discourse and knowledge of sexuality. To Foucault (1972:8) discourse operates at different levels as "the general domain of all statements, sometimes as an individualizable group of statements, and sometimes a regulated practice that accounts for a number of statements". Using this view, he developed a methodological approach to study discourse which focused on revealing power and knowledge networks to challenge us in our traditional concept of power as repressive, to rethink power in a contemporary social and political perspective. Foucault's (Ibid) basis of power as being exercised to circulate throughout the entire social body to produce knowledge that individuals who are subjected to power are at the same time, subjects of power. Foucault (1980) calls this form of power 'bio-power'. To him (Ibid), 'bio-power' coalesced between two poles; where on one, it is the efficient government of the population as a whole and on the other, the 'disciplinary power' which concentrates on manipulating and training the population for social regulation and controls. As explained by him, 'bio-power' has a constitutive role in forming knowledge as truth. In other words, 'truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power' (Ibid: 131).

By this, nurses who had been regarded as powerless under the 'bio-power' of the healthcare system were not helpless victims. Foucault's regimes of 'power/knowledge' as structured ways of knowing and exercising power was therefore useful for unpacking the process of professionalisation nursing effort in Singapore.

Context Of Analysis

In Foucault's (1977) work, discourse is taken as more than the language we speak, it is a social practice in a relationship we have in and with the world. Hence, individuals are believed to be enmeshed in different discourses (Wodak and Meyer 2009). Nevertheless, privileged discourse could subordinate other discourses to structure our realities, which are known as 'truths' (Foucault 1977). Central to today's nursing practice is economic discourse, which was particularly powerful and influential during healthcare reforms. By focusing the analysis on a neo-classic economic discourse which has a strong emphasis on productivity, cost effectiveness and competitiveness, an understanding of how nursing was subverted to the extent that nurses' activities were molded to potentially help with achieving professional status could be determined. As advised by Foucault (2002), seeking general history of the specific discursive event is important for an understanding of its inconsistencies and silences related to the topic in question. Keeping this in mind, context of the current analysis was not only based on information on local nursing clinical and educational practices between 1993 and 2014, but also information which tracked back to 1985 when the healthcare system was reformed and privatised under the initiatives of the Singapore government.

Findings of the Analysis

Institutions as a regime of 'bio-power'

Since the mid-1980s, nursing practice in Singapore has been confined to large teaching and acute care hospitals, specialty centres, polyclinics and institutionalised nursing homes. Each of these concrete structures was departmentalised into various functional organisations and/or specialised medical units. In Foucault's (1984) term, these institutions are historically a variable regime

of 'bio-power' in which nurses were required to be efficient and were capable enough to bear responsibilities for patient safety. Apparently, the historical specificity of nursing was formed as highly efficient and in some cases, specialised, just so that nurses could meet individualised patient medical needs within a variety of multi-cultural, religious, lingual and ethnic/racial contexts. Through healthcare reform and successful corporatisation between 1985 and 2002, high quality nursing practice was further emphasised with an aim to achieve the common good that was in the Singapore public interest; specifically, through positioning Singapore as a health hub for international clients and at the same time, as an affordable healthcare service for the locals (Lim 2005). Emerging from this political drive was a business-like healthcare system in which nursing clinical competence based on a bio-medical model and physical sciences was required even more than before.

In the mid-2000s, part of the global professionalisation effort had led nursing education in the West to increasingly migrate to degree level. While the rest of the world held strong views about higher education as the route to professionalisation (Watkins 2011, Öhlén 2011), Singapore has expanded nursing education provision at diploma and certificate levels. Nursing schools at a second polytechnic for diploma nursing and a vocational institution for certificate nursing were erected (Loke 2014). Nursing education at University level was not possible until a 10 million dollar donation was received from the Lee Foundation to establish the Alice Lee Centre (ALCN) in 2006 (National University of Singapore 2013/14). In the country, polytechnics were the main nursing education providers where registered nurses were generated in large volumes alongside the production of enrolled nurses from the vocational institution. Such practice continued albeit the general view that nursing staff produced at low academic levels threatened the professionalisation process (Law and Aranda 2010).

Relational structures of power

While shifting away from a medical model is the trend in the Western nursing curriculum, clinical skills and knowledge acquisition based on bio-medical and physical sciences were strongly emphasised in Singapore's

nursing curricula (Loke and Lee 2015). In addition, many nursing faculties in developed countries like Australia, England and North America are operating independently. In contrast to the general scene, the ALCN existed as a centre of the Yong Loo Ling School of Medicine. Above this, the preparation of the Advance Practice Nursing (APN) roles at Master's degree level which was co-initiated by a nurse in 2003 was made viable by the active involvement of medical professionals in teaching and supervision. Nurses are co-taught and supervised by medical doctors who would see that any qualified APNs had the required capacity for working in an intimate professional partnership with medical doctors (Kannusamy 2006). This continuing dependence on medicine for knowledge which contradicted the general consensus about nursing autonomy in the professionalisation process has helped nurses maintain a good clinical acumen, which is important for nurses in their advanced roles. The heavy reliance on medical knowledge has since allowed nursing in Singapore to expand into many healthcare areas which were once, exclusive territories of junior doctors.

Apparently, the entire nursing education system has continued to be bound to medicine; implicitly at certificate, diploma and basic degree levels, and explicitly at post graduate levels. Nursing education appeared to be fulfilling the aim of continuous preparation of nurses with competent clinical skills to complement the role of medical doctors. While it was not clear if this has enhanced the intimate professional relationship between the two disciplines, certainly by the late 1990s, nurses started receiving research guidance and support from the more able medical doctors. Consequently, collaborative research work with medical doctors was secured and nursing papers were increasingly published in the Singapore Medical Journal. By the new millennium, research papers by clinical nurses had even made their appearances in renowned international nursing journals (Ayre et al. 2007, Chan et al. 2011, Tiew and Creedy 2011).

It was clear that nursing spanning from educational to clinical practices and research still continued to tag on to medicine. Nursing autonomy might still be exercised, but it was likely to be

restricted as defined by the various nursing positions. If nursing was viewed with reference to the social role of 'females' and medicine was to that of 'males', nursing across all fields in Singapore was not far from the observations made not long ago by James (1992) and Smith (1993) who both saw nursing as an expansion of the physical and emotional work of wives and mothers. The doctor-nurse power-relations, a persistent concern in the West for its potential for de-professionalising nursing (Witz 1992), were actively constructed in Singapore. The interesting observation was that the power-relations that resulted in nurses' continuous 'submissive subordination' to medical doctors had produced a collegiate working relationship between them. The culture of interprofessional learning and working was achieved and less problematic, as observed outside Singapore (Becker et al. 2000, King et al. 2009, Loke et al. 2011).

Governmentality for self management

The corporatisation of healthcare institutions in the early 1990s resulted in effects which were similar to what Foucault (1984) recognised during the reformation of hospitals in the 18th century. Health institutions reformed as 'curing machines' were subject to governmentality which Foucault (1984) referred to as measurements of control. This was observed since corporatisation, where intense effort was mobilised by health institutions, aimed to confer with the International Standard of Organisation (ISO) certification for 'quality management system'. Recently, effort for quality rewards has extended to the pursuit of more prestigious recognition; the 'Joint Commission International' (JCI) and 'Singapore Service Class'. All these demanded higher quality and cost effective nursing care. These observations illustrated the fact that constituted in the government's initiatives and priority was one legitimised image of a nurse; an individual with the ability to deliver not only safe but also, excellent care that would at all times, exceed the expectations of the patients as 'customers'. This discourse then became privileged and hence, sustained the general understanding that nursing practice required tighter measures and control. Individuals who wished to remain in the profession would conform to the predominant culture of nursing even if the undertaking involved one's own costs and time (Boey

1998). It was therefore common for qualified nurses to pay out of their own pockets to upgrade nursing knowledge and skills through the pursuit of a top up degree or continuing professional development programmes (CPD).

Subject of power versus subject to power

While the segregation in nursing educational provisions had continued to maintain the two distinct categories of nursing, career advancement was not necessarily based on individuals' educational qualifications, but nurses' ability to normalise to the standards of nursing. In other words, promotions were given to individuals who could maintain the discipline to a high standard (Lee 2005). Emerged in the Singapore healthcare atmosphere, where high quality was emphasised as the critical key to institutional success was nursing as a direct locus of social control for high quality nursing. Other than regular formal surveillance during the yearly performance appraisals imposed by the institutions, nursing practice was often subjected to informal peer reviews. Not only nurses who were senior in positions, but those who had more years in employment would automatically assume the monitoring and supervisory roles for ensuring good nursing standards. On this note, it is worth mentioning that foreigners who made up about 50% of the nursing work force had less years of work experience in Singapore, these degree holders were actively recruited to address nursing shortages in the country (Coe and Kelly 2002, Lim 2005, SNB 2013). Since, foreign nurses had limited contextual nursing knowledge (Ng 2011), many local nurses who had not a higher education qualification automatically assume the role as 'supervisors'. This easily led to productive operation of power-relations, which could be disguised as the need to construct a nurse with good who is effective to fit in the local context. Otherwise, the quest for excellence which had led to an amplified enthusiasm for intense surveillance and control, could subliminally invite increased institutional violence (St-Pierre and Holmes 2008) or bullying from racial discrimination (Alexis and Vydelingum 2005, Kushnick 1988, Taylor 2005).

In so far, nurses were imposed by a vast array of disciplinary techniques within the hierarchical nursing system,

yet the regime of power from governmental directives appeared to have been internalised by nurses, including the non-Singaporeans. How this has been possible was by the many carefully crafted strategies employed to address potential disharmony in the workplace. One common way was the use of work improvement projects (WIPs) to address the different aspects of work issues. The use of WIPs may subject nurses to yet another form of surveillance and continuous scrutiny by peers, but the focus of WIPs was on work processes aiming at team building, managing and problem solving techniques, as well as innovation and continuous improvement processes (Bessant et al. 2001, Somasundaram and Badiru 1992, van't Veer 1991). Hence, nurses at all levels regardless of their origins could be socialised at ease to internalise the government regime; in other words, they were likely to engage in continuous generation of knowledge which was in line with the institutional vision and mission for excellence.

Critical Remarks

The reforming of the healthcare system had facilitated the expansion of disciplinary techniques for control and measures of quality standards within the health institutions (Foucault 1984). Through such governmentality, certain forms of power were then made historically possible. Singapore Healthcare institutions - governed by the healthcare policies were culturally constructed to be in power to determine the conditions under which nursing behaviours could be counted as 'correct' and others, as 'wrong'. In this way, nurses' performances continued to be measured against the range of standards as created by the institutions as the 'bio power'. In many ways, nurses were subjected to power in their subservient roles in the hierarchical structure to support the Singapore government – the policymaker and regulator of the entire healthcare system (Lim 2005). Had nurses not been in a subservient role, they would be on the other end of the scale of normalisation; attempts to professionalise nursing would have been made to liberate oneself from the political power for emancipation through trade unions and/or strikes that could cost the country massive amounts of revenue (Keogh 1997, The Telegraph 2011).

However, while being a subject to power, there was more to meet the eyes in nurses' subservient role. It was interesting to see how by being the subject to power and the constructed power/knowledge, nurses in Singapore had in fact led themselves to become the subject of power. In Foucault's term (1980) determinants of nursing behaviours as constituted 'knowledge' would also act as a benchmark for nurses, who in their own minds become regulatory agents for themselves and also others to achieve a scale of normalising behaviour, which was understood as acceptable (safe) and excellent (outstanding) nursing practice. By this, each and every nurse was also a subject of political power in which nurses' dominant role was maintained. Hence, even when the country was challenged by the downturn of the economy in the late 1990s, nurses were still demonstrating a high level of job satisfaction (Boey 1999, Fang 2001, Loke 2001).

Without nurses being in their dual capacity as subject of power and subject to power, nurses would not have been able to share the government's vision in becoming the health hub and would instead, resist the imposition even if the strategies were targeted at achieving quality patient care. Clearly, those who remained in nursing were in line with the governmental policies and were in favour of the medico-political power. Evidently, while organisational commitment and job satisfaction were the top predictors of nursing turnover intention in the country (Fang 2001), nurses who were in a more intimate professional partnership with medical professionals in highly specialised areas were found to be more likely to stay in nursing (Chan et al. 2000). Immersing in the nurse-nurse and nurse-doctor power relations, nursing continues to be self retained by nurses as the locus control of power, working towards normalization of disciplinary practices that were under the mechanics of the patriarchal social structure. As such, high standard patient care in the most cost effective way was consistently guaranteed to drive the nursing profession forward.

This argument was not put forward to deny the possibility of nurses disagreeing with the 'created' knowledge. It is also not to suggest that we should naively ignore the fact that resistance of institutional dominance exists. It is

appreciated that there were bound to be individuals who would not capitalise on the power-relations as effectively, and would end up leaving the profession. This unwanted effect is quite significant and accounted for the phenomenon of a high percentage of non-practising nurses; 15% RNs and 16% ENs had persisted from 2011-2013 (SNB 2013). In Singapore, vacancies for nursing which were created by those who resisted the legitimated power/knowledge were quickly filled by the influx of nurses from nearby Asian countries. By 2013, 25% of the registered nurse population was non-Singaporeans (SNB, 2013). Given the fact that many of these nurses were from developing East/Asian countries, they were equally influenced by the strong values about women subservient roles in societies, that their presence was likely to enhance Singapore's patriarchal dominance on the development in nursing.

Conclusion

The professionalisation of nursing effort in Singapore did not rely on the grandiosity of higher education, but the power relations intimately interwoven in nurse-nurse and nurse-doctor interactions. These, which strengthened the hierarchical nursing structure, formed the basis for good quality nursing. The valid and legitimate knowledge about nursing generated through neo-classical commercial discourse defined the high standard of nursing practices. This then provided a frame of reference for nurses' continuous interpreting and generating a particular understanding of nursing, that it demanded a consistent high quality standard of nursing practices. The apparent pervasiveness of power-relations in all aspects of nursing practice as a phenomenon to professionalise nursing was indeed a feature of the rationalisation and calculative technologies associated with commercialism based on the government's priority to turn Singapore into a medical health hub. As

such, the pursuit of specialised nursing knowledge and autonomous nursing practice was not only for the common good but more important, was in favour of the Singapore public interest. Without generalising the positive effects of the power-relations in Singapore, nursing practice which reflected the 'subservience in females' and demonstrated respect for authority within a hierarchical system had evidently led to good quality nursing practices which serve as a strong foundation for nursing to secure professional recognition.

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