ORIGINAL ARTICLE

Professionalising care into compliance: The challenge for personalised care models

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Abstract

One of the most basic understandings of nursing is that a nurse is a caregiver for a patient who helps to prevent illness, treat health conditions, and manage the physical needs of patients. Nursing is often presented as a caring profession, which provides patient care driven by ideals of empathy, compassion and kindness. These ideals of care have further been foregrounded through the development and implementation of stress on patient centred care (PCC) and/or person-centred practice (PCP). Although the idealisation of nursing as a caring profession is common, and one certainly seen as integral by nurses and written into the heart of regulatory documentation, we contend that the actual delivery of care is being undercut by the very regulatory climate that strives to professionalise care. As we outline, with specific reference to the context of Australian Nursing, this transformation delivers a commodified, even McDonaldized, model of patient management rather than care. It seems that even with its explicit stress on PCC and PCP, Australian Nursing cannot live up to its own care ideals. Having outlined this problem, the paper then demonstrates the ways in which PCC is thwarted at the coal face of nursing practice and that there must be an institutionalised change to be able to provide genuine patient-centred care.

KEYWORDS
care, duty of care, patient centred care, person centred practice, professionalisation

1 | INTRODUCTION

One of the most basic understandings of nursing is that a nurse is a caregiver for patients and in that role helps to prevent illness, treat health conditions and manage the physical needs of patients. Nursing is indeed often presented as a caring profession, with patient care driven by ideals of empathy, compassion and kindness. Nightingale, for example, conceptualised nursing as alleviating suffering through acts of compassion (Kaplan et al., 2016; Mascaro et al., 2015; Straughair, 2012a, 2012b), but also aligned it with such moral virtues as kindness, compassion and competence (Bradshaw, 2011; Zulueta, 2013). Indeed, it is often highlighted that nurses should be empathetic, compassionate, kind and trustworthy (Alicea-Planas, 2016; McKeown et al., 2014; Pacquiao, 2008). Given this focus, it is unsurprising that the concept of care is often revered for its relational, emotional and feminine qualities (Bradshaw, 2009). Such a focus is further stressed in the development and implementation of stress on patient centred care (PCC) and/or person-centred practice (PCP).

Although this kind of idealisation of nursing as a caring profession is common, and one certainly still seen as integral by

nurses, we suggest the current regulatory climate of nursing is not supportive of these ideals of care. More specifically, while care continues to be foregrounded in PCC and PCP descriptions of nursing ideals, in practice it has been overlaid by multiple layers of legislation, standards and propaganda. Care has been transformed into a highly regulated and regulating model of compliance. Put another way, given the increasing strength of stresses on efficiency, calculability, predictability and control in nursing, care has been professionalised and commodified. This has been to such an extent that it is unclear whether nursing practice continues to be oriented to and by care in its actual practice. The focus of this paper, then, is to examine the ideals of care as they are written into nursing roles and expectations and to explore what is left of these ideals once they are considered in the context of the various constraints built into the professionalised and compliance-driven concept of duty of care. More specifically, this paper examines these issues in the context of Australian Nursing and is informed in particular by a detailed analysis of Australian standards and codes of nursing.

2 | UNDERSTANDING CARE

From a consumer perspective, the work of Hofmeyer et al. (2018) has identified that it is a public expectation that nursing care is not only technically excellent but also compassionate and personalised. Such conceptions of care align closely with several of the concepts considered significant for the PCC framework (Crowther et al., 2013; Faust, 2009). PCC outlines the idea of care in terms of nurses being respectful, responsive to patient needs and wants, and striving to incorporate patient values in treatment decisions (Hower et al., 2019; Richardson et al., 2001). PCC, in other words, involves treating people as unique and relies on the customisation of care. PCC further assumes that patients possess expertise with regard to their own disease and should feel empowered within healthcare decision-making. These assumptions guide the development of a therapeutic relationship between nurse and patient where this relationship demonstrates a strong foundation of respect, interpersonal skills and knowledge of each patient's personal context and preferences (Hofmeyer et al., 2018).

PCC and PCP also stress relationality, recognising that the patient who needs care and consideration within the healthcare setting is socially and culturally situated, typically understanding themselves and their healthcare in reference to their social relationships and connections with others (Santana et al., 2017). PCC and PCP, thus, strive to view patients holistically and consider a range of the complexities of human nature with regard to healthcare (El-Alti et al., 2019). These various ideals mean that skills such as active listening and being able to adequately respond to another's pain or suffering are considered key in the delivery of patient care (Hofmeyer et al., 2018). Mace (2012) further notes the importance of kind words and gentle touches to reduce possible problems of power imbalances in therapeutic relationships. In broad terms, the incorporation of PCC

and/or PCP orientations into nursing practice has been demonstrated to improve patient outcomes, patient satisfaction and patient well-being (Berghout et al., 2015; Fix et al., 2017). Illustrating the interconnections of care with a suite of other moral values, the Australian code of ethics for nurses (Nursing and Midwifery Board of Australia, NMBA, 2008a) refers to kindness as demonstrative of gentleness, consideration and care; further describing compassion as based upon empathy (Straughair, 2012b). This is supported by the adoption of the 2012 International Council of Nurses Code of Ethics which also identifies the need to alleviate suffering.

In the Australian context, commitment to PCC and PCP is now a standard requirement for organisations to be able to gain accreditation (Byrne et al., 2020). Indeed, PCC and PCP expectations and requirements are standard inclusions with Australian nursing regulatory documents. For example, the standards for practice for the registered nurse (RN) (NMBA, 2016) stress the importance of nurses building collaborative and respectful nurse–patient partnerships and treatment regimens that are built on mutual trust and understanding. These standards further recognise the importance of individualised conceptualisations of the person and care (NMBA, 2016). The idea here is that such conceptions work to protect the individual's rights, dignity and care preferences, and empower them to make appropriate choices for their own unique circumstances (NMBA, 2016). Some of the ways these Standards foreground the importance of individualising care are illustrated below (see Table 1).

3 | REGULATING CARE

What the Australian regulatory documents also stress is that alongside their provision of care through the terms of PCC and PCP, nurses are expected to meet high levels of ethical, technical, moral and legal responsibility in relation to the nursing care they provide. This stress is visible within each of the standards. Such a focus connects with a nurse's duty of care. In broad terms, the principle of duty of care is that the healthcare professional has an obligation to avoid acts or omissions which could be reasonably foreseen to injure or harm other people (Sheahan & Lamont, 2020). This is the idea that Stuifbergen and Van Delden (2011) discuss in their work, that if an individual is vulnerable or dependent on another, then the other person has a responsibility to protect that dependent person. It is understood that the duty of care and the subsequent legal responsibility of the healthcare professional towards the patient begins when the healthcare professional accepts responsibility for the treatment of the patient (Kelly, 2010). Such responsibilities are written as professional virtues and principles (Reid, 2005) which tend in turn to be foregrounded in codes of ethics and standards for professional conduct. Table 2 illustrates these points with reference to the code of ethics for nurses in Australia (NMBA, 2008b), the code of professional conduct for nurses in Australia (NMBA, 2008a) and the standards for practice for the RN (NMBA, 2016).

TABLE 1 Foregrounding the individualising of care

Standard 1: *Thinks critically and analyses nursing practice [...] within person-centred and evidence-based frameworks*	• Point 1.3: [RNs should respect] *all cultures and experiences, which includes responding to the role of the family and community that underpin the health of Aboriginal and Torres strait islander peoples and people of other cultures*
Standard 2: *Engages in therapeutic and professional relationships*	• Point 2.2: [An RN should] *communicate effectively, and is respectful of a person's dignity, culture, values, belief and rights* • Point 2.3: [RNs should recognise that] *people are the experts in the experience of their life* • Point 2.5: [RNs should] *advocate on behalf of people in a manner that respects the person's autonomy and legal capacity*
Standard 4: *Comprehensively conducts assessments*	• Point 4.1: [RNs should conduct] *assessments that are holistic as well as culturally appropriate*

Note: Standards for practice for the RN (NMBA, 2016).
Abbreviation: RN, Registered Nurse.

TABLE 2 Professionalising care through codes of ethics and professional practice.

Code of ethics for nurses in Australia	Code of professional conduct for nurses in Australia	Standards for practice for the Registered Nurse
Value Statement 1: Nurses are required to value quality nursing care for all people	Conduct Statement 1: Nurses practice in a safe and competent manner	Standard 3: *Maintains the capability for practice*
Value Statement 6: Nurses need to engage in a culture of safety through processes such as prevention, monitoring, early identification and early management	Conduct Statement 2: Nurses practise in accordance with the standards of the profession and broader health system	Standard 6: Provides, safe, appropriate and responsive quality nursing practice [... using ...] the best available evidence to achieve planned and agreed outcomes

What this framing of care as a duty of care does, then, is to transform care from an individualised focus and practice into a professional discourse of competency (Eisenberg, 1990), where the scope of practice, particularly in nursing practice, is tied in with evidence-based practice (Young, 2009). Negligence is, in turn, defined with reference to the professional role and the duty of performing that role to a specified standard (Eisenberg, 1990; Young, 2009). Young (2009), thus, identifies that in nursing practice, the scope of practice for both care and competence are linked with the standards of practice and the codes that frame and determine appropriate nursing practice.

The point here is that while ideals of care clearly underpin such statements and standards, these ideals are written into broader professional standards of competency. Furthermore, nurses engage with these standards in complex healthcare settings where organisational, institutional and legal constraints always influence the enactment of care. These features of healthcare have together meant that care ideals have been converted into a range of standardised protocols that—based on generic evidence-based practice guidelines and interventions— work to limit risk (El-Alti et al., 2019). Common protocols— outlined briefly below—include mechanisms of standardised care plans (SCPs), self-regulation, distancing and discretion. While each of these can be seen as strategies to enable nurses to perform patient care consistently and to the standards of evidence-based best practice within a framework of institutional and professionalised demands, they also work to maximise the functionality of healthcare settings (Perron, 2013) and can promote a checklist mentality (Byrne et al., 2020).

3.1 | Standardised care plans

SCPs enable external monitoring of practice. While they can certainly be defined to introduce high-quality, evidence-based cost-effective care that clearly defines the standards of care, expected outcomes and timeframes for selected patient groups (Ballantyne, 2016; Dahm & Wadensten, 2008), SCPs institutionalise ideas regarding 'good' care through their operation. They make nursing practice accountable under a one size fits all model and establish frameworks for the surveillance of both the worker and the service user. Garrett (2003), for instance, has recognised that care plans can be used mechanistically as checklists without differentiation or consideration of the 'variants', or individual responses, to illness and, therefore, recovery. SCPs can thus be seen as processes of protocolisation, which are aimed to reduce the time spent on activities and to monitor the productivity of staff. In addition, in providing timeframes of managed care that are authorised and normalised for patients with stated conditions, such plans can exacerbate neglect of the sociocultural backgrounds of patients (Booth et al., 2006). Such regulation of nursing practice and the standardisation of nursing practice through national registration schemes and SCPs thus subtly shift the focus from the provision of personalised care towards a focus on standardisation, surveillance and monitoring.

3.2 | Self-regulation

As has been noted, there are several key regulating bodies that influence and monitor the Australian nursing profession as well as individual nurses concerning their practice. What these various documents all make clear is that it is each nurse's responsibility to regulate their own—and others'—professional capacity. Indeed, the nursing profession—and these various standards—are heavily reliant on the ability of its members to self-regulate (van Rensburg et al., 2016). Such expectations are summed up, for example, in the code of professional conduct of nurses in Australia (NMBA, 2008b) where, in Conduct Statement 10, it is stated that the nurse is expected to *practice reflectively and ethically and learn through experience and contribute to both their professional and personal practice and to the development of others*. As this statement illustrates, self-regulation is dynamic in its focus on competence and areas for improvement (Kuiper et al., 2009). Reflection is, thus, a key mechanism for nurses to monitor and adapt their behaviour in line with professional and organisational expectations (Gilbert, 2001).

3.3 | Distancing

Despite the promotion of personalised and patient-centred care practises in standards and nursing literature, Zulueta (2013) and Kagan (2016) also note ways that the compassionate dimensions of nursing can be said to wane within professionalised conceptions of practice. One of these—referred to here as distancing (as well as other emotional management strategies)—can be understood as a protective mechanism by nurses to protect themselves from emotional and psychological burnout (see, e.g., Hayward & Tuckey, 2011; Kinman & Leggetter, 2016). Such practises refer to the 'manipulation of emotional boundaries, to create an emotional distance [...] with patients' (Hayward & Tuckey, 2011, p. 1501). For example, in handover, the use of patient diagnoses to discuss patients is common. Thus, handover might discuss Bed 1—Mrs Jones type 1 diabetic with below-knee amputation. This has the potential to reduce patients to their conditions and to the ritualised tasks that nurses perform for these patients such as wound dressing, activities of daily living and medications. In emergency situations, patients can also become their observations, and focus is again placed on the ritualised, mechanistic tasks that are associated with the deteriorating patient. In addition, while students are taught in study programmes to maintain patient confidentiality and privacy, this also has the potential, in practice, to lead to talking about patients by their conditions and or surgeries. While such practises are performed under the guise of making emotionally and psychologically challenging patient encounters easier to deal with for nurses and other healthcare professionals, they have also been identified as counter-productive for caring. Schmidt (2003, p. 395), for instance, emphasises that patients expect to be treated as individuals and to be known by more than their diagnosis.

3.4 | Discretion versus manipulation

Durose (2011) understands that discretion within the nursing practice is the operation of a form of judgement within recognised professional boundaries. Indeed, the exercise of discretion is often taken as the archetypal activity that defines professional practice and has provided the focus for a significant amount of debate and analysis concerning the status of professions (Hunt, 1997). According to Hoyle (2014) and Taylor and Kelly (2006), there are three types of discretion in practice in nursing: (a) rule discretion, bounded by legal, fiscal or organisational constraints; (b) value discretion, determined by notions of fairness or justice and involving professional and organisational codes of conduct and ethics; and (c) task discretion, the ability to carry out prescribed nursing tasks. As is evident, the process of discretionary judgement is based heavily on the accepted frameworks of professional obligation and ethical conduct—duty of care—that inform the behaviour of healthcare professionals toward patients (Gambrill, 2010). The use of discretion is, hence, about the interpretation of rules and policies according to which professionals fill in the blanks between the rhetoric of practice outlined in these policies and rules and actual practice.

4 | THE CHALLENGE OF CARE

As we have noted, what these various mechanisms—SCPs, self-regulation, distancing and discretion—would seem to enable is a focus on surveillance and on professional distance. Such features may, of course, be seen as important for the provision of equitable and just care, but they do also seem to mean that the ideal of personalised customisable care becomes a potential 'extra'. That is, the standardised care of SCPs that is enabled and monitored through practices of self-regulation, distancing, and discretion is arguably driven by a foregrounding of efficiency, calculability, predictability and control. These are the dimensions of what has been called the McDonaldization of care (Ritzer, 1996). Ritzer (1996, p. 35) describes the McDonaldization effect as meaning that 'expectations regarding efficiency and control become enforced to the point that individuals are expected to comply with professional and organisational rules and regulations without question'. Such an effect is clearly illustrated in the hierarchical and organisational control of the hospital over both patients and nurses. Nurses, for instance, when employed by an organisation, are expected to conform to the rules and regulations of not only the profession of nursing, but also the organisation itself. They are also monitored with regard to their maintenance of their professional capabilities for practice in accordance with Australian standards and regulations. Patients too are required to abide by organisational requirements. Indeed, these requirements mark the deidentification of individuals into patients who are required to dress a certain way and are identified and known either via their suite of conditions or a unit record number.

With its focus on calculability, predictability and control, the McDonaldization of care also marks the assumption that all

interactions and events can be calculated, counted and quantified (Sturgeon, 2010). Indeed, the McDonaldization of care aligns with the idea that the standards and guidelines that influence nursing practice need to be universally adopted by nursing staff to minimise institutional risk (Bradshaw, 2016). This, as mentioned above, is foregrounded in clinical practice using things such as SCPs. The stress on calculability, predictability and control is further apparent in the reliance on techniques of self-regulation, distancing and discretion within the healthcare setting. Although such techniques are typically described as necessary for ensuring conformity of care, they can also mean that nursing tasks become mechanical in nature and dehumanising for both patients and nurses (Bradshaw, 2016). Making it easy to foreground patient management over personalised care, such techniques can influence the connection between the nurse and the patient to the point that it can become scripted, superficial and disembodied (Austin, 2011). One pertinent illustration of such dehumanising is what was previously described where patients are referred to as their disease processes—a model that clearly neglects the lived experiences of the individual (Norlyk et al., 2017).

As we have noted, these pressures towards management and standardisation are concerning insofar as they would seem to turn nursing's attention away from the customising of care. We would further suggest that these various pressures can entail professional and institutional stress on compliance to the point that compliance becomes a focus in and of itself rather than remaining in perspective as a measure towards implementing equitable, just, and effective patient care. To be more specific again, our suspicion is that the practice of compliance that is being inculcated by a nursing culture built on calculability, predictability and control has watered down the capacity to deliver personalised care in practice. This is the point that while PCC is integral to the accreditation process and espoused as being integral to good nursing practice, there seems to be a disconnection between what happens in practice (SCPs, self-regulation, distancing and discretion) versus the actual ambitions of PCC to deliver personalised care. Such disconnect is also noted by Richards and Borglin (2019, p. 150) who see a highly problematic divide between caring nursing practice and the meeting of institutional requirements—a divide that they suggest indicates not only the breaking of the 'social contract' between the nursing profession and society but the 'immaturity' of the profession. Hall and Høy (2012) recognise that managing illness, time and workload can make individualised care hard to achieve. Corbin (2008) also recognises that caring has become at odds with the working conditions that many nurses are faced with, including the use of new technologies. Here, Corbin (2008) notes that not only are some nursing practises being replaced by more cost-effective technology-driven measures, but that nurses too are being taken away from caregiving through management—and, Richards and Borglin (2019) would add, leadership—requirements.

This disconnect is also evident in other ways. There is, in the first instance, an impact on nurses from the contradictory demands on them, and from delivering care that is both constrained and lacking in professional autonomy. More specifically, nurses have been found to feel stressed, overwhelmed, powerless, burnt out and dissatisfied with their jobs—feelings that have been summed up as indicating 'compassion fatigue'. This compassion fatigue, initially described by Joinson (1992), can lead to tensions within the nurse–patient relationship and can constrain nurses' ability to feel sympathy and empathy toward patients (Xie et al., 2021). Compassion fatigue also distributes power away from the consumer, challenging attempts to empower patients to share in decision-making (Cole, 2019). Such issues further highlight the slippage between ideals and practice.

Second, as we have noted, nurse education in Australia certainly includes the fundamentals of PCC but it also stresses the importance of standardised care and teaches strategies for patient management. In addition, while student nurses are at least taught the fundamentals of PCC, not only is there typically little institutional focus on delivering personalised care but there is little professional development (PD) in PCC offered to work nurses on the front line of care. That is, PD opportunities for working nurses most typically focus on technical issues and equipment. This is exemplified by consideration of the PD opportunities made available to staff associated with major tertiary hospitals in Victoria, Australia. From searches carried out in late 2021, what stands out is that many nurse PD opportunities on offer, either through third-party education providers or in conjunction with universities, focus on clinical and technical skills and their further development. For example, a major tertiary hospital in 2021 in metropolitan Melbourne only offered its staff PD in Advanced Life Support and Advanced Wound Care.

The third illustration of this disconnect between practice and theory—between personalised care and certain ideas of professionalism—is also evident in the ways Australian healthcare providers report back on their delivery of PCC. As Harper et al. (2020) recognise, the skills that are needed to provide PCC are often hard to observe or measure, given their close interconnection with patient experience. This has meant that the standard way of measuring the implementation of PCC has involved patient surveys —the Victorian Health Experience Survey (2016–2018) being one such example. Although such surveys try to cover all aspects of hospital admission and patient experience, what tends to be focused upon in practice are the dimensions of care and the patient experience that are easily measured and can be easily improved through institutional measures. Thus, questions ask about the rating of hospital food and whether hospital staff washed their hands, used hand gel to clean their hands, or put on clean gloves before any examinations (Wong et al., 2020). Other questions may ask whether the patient felt involved in decisions about their discharge from hospital (Wong et al., 2020). There are two concerns here. First is whether such questions address and evaluate the delivery of PCC. The second concerns the use of any collected data. Regarding this latter issue, while this data is collected, only certain aspects of it are filtered down to the staff responsible for delivering care. More specifically, what is filtered down to staff is generally to do with the occurrence of any sentinel or adverse patient safety events that would have been preventable, and which resulted in serious harm to, or death of, a patient (Australian Commission on Safety and Quality in

Healthcare, ACSQH, 2019). Such information is, of course, important, but if this is the only data regarding patient experience delivered back to staff, it maintains stress on compliance and accountability regarding patient safety rather than on improving the capacity of staff to deliver care across all the dimensions comprising PCC.

To put these issues another way, it is certainly the case that sentinel event reporting works to ensure public accountability and transparency and to drive national improvement in patient safety—key aims for the Australian Commission on Safety and Quality in Healthcare (ACSQH, 2019)—as well as helping address poor practice standards and detect any fraudulent activity (Australian Government Department of Health, 2021). Patient safety remains, however, only one small part of patient experience and only one small part of implementing PCC. Indeed, such an emphasis is a further indicator that, despite the stress being given to the ideals of PCC, the biomedicalised dimensions of healthcare clearly continue to be given priority in practice within Australia. As noted, these dimensions are certainly important but it has also been accepted that such a focus does little to address the psychosocial and relational dimensions of patient care, and further has a tendency to overlook patient voice and experience—the very dimensions of healthcare PCC is supposed to address and deliver. This makes the key question one of identifying how healthcare and nurses might continue managing patient acuity and safety whilst strengthening the patient voice and delivering truly personalised care.

This is of course the overarching question for healthcare and PCC. As we have shown, it is also the question that remains unaddressed as healthcare and nursing practices continue to emphasise the standardisation of care, compliance and patient safety over patient voice and the delivery of customised care. Although the full address of this question—and the full delivery of PCC—is not yet visible in the Australian context, one issue does stand out as in need of consideration. This concerns the time pressures that have become standardised for nurses. Nurses continue to be time poor, and compliance-driven, resulting in the stresses on efficiency, calcul-ability, predictability and control that have led to what has been called the McDonaldization of care discussed previously and what we and others have diagnosed as an ongoing disconnect between the theory, ideals, and the actual delivery of PCC. At the institutional level in the Australian context, these points have come to mean that at least a portion of the relational and psychosocial care and support work seen as fundamental in PCC is being carried out not by nurses or even by other healthcare staff but rather by community volunteers (see, e.g., Government of Western Australia Child and Adolescent Health Services Volunteer Management). There are several points that arise from this. The first is to remember that the delivery of authentic PCC perhaps needs to be recognised as being the responsibility not just of nurses but of a multidisciplinary team that perhaps also incorporates community volunteer care and support work. At the same time, it should also be noted that having even some of the dimensions of customised care that are committed to by institutions—and that are further part of their accreditation requirements—delivered by volunteers underscores a lack of institutional commitment to delivering PCC across all its dimensions. This lack of commitment and delivery is, of course, also enabled by the very limited evaluation models used by institutions and the healthcare professional regarding their actual delivery of PCC.

In other words, perhaps the first step with regard to revising the delivery of PCC is to build institutional and professional under-standing and commitment to not just the rhetoric of PCC but its delivery. This would involve concerted work to map PCC ideals against patient experience—actual and preferred— along with the identification of all stakeholders and the determination of potential points of accountability for full implementation of PCC. This would encompass the revisioning of nursing roles and work (and, perhaps, workload), as well as of the structures and work of the multi-disciplinary teams that are engaged with patients and their care, as well as an organisational culture shift to accommodate the PCC model of care—one that truly puts patients front and centre. We have argued elsewhere that such a shift might align well with the implementation of patient empowerment theories and models (Cole et al., 2022), but this too also requires PCC to be better valued and assessed throughout all the institutional and professional contexts of healthcare. Richards and Borglin (2019) also suggest some mecha-nisms that might assist in realigning nursing work to the delivery of care. Of these, two stand out. First is the instigation of programmes to 're-value and re-incentivise the practice of fundamental nursing care' to the point that nurse career advancement can also be founded in core nursing roles rather than in 'medical substitution or clinically remote administration roles' (p. 151). The second involves a substantial investment in fundamental nursing care research to ground the call for revaluing fundamental nursing care (p. 151). Achieving Richards and Borglin's recommendations would, we believe, support the achievement of our recommendations.

Two points do stand out with reference to these various recommendations, both ours and those by Richards and Borglin. First is the point that none of these recommendations fall completely to nurses. Strong nurse voices and commitments towards PCC are extremely important—particularly for the achievement of Richards and Borglin's recommendations—given that nurses and other health professionals are active agents who are not only shaped by external forces but also shape them. Hence, there is a need for all health professionals to assume their responsibilities regarding the delivery of PCC. But what is also fundamental is for the broader institutions engaged in healthcare provision, education and regulation to also commit their support for change. The second point is that while such commitments have been called for before – insofar as the caring paradigm has been propounded since the 1960s when this concept became more popular with the shift from a biomedical model—there are a range of factors at work that make current calls compelling. First is growing professional, political and public awareness of the stresses currently impacting healthcare globally (see, e.g., Richards & Borglin, 2019). Second is the growing attention being placed on consumer rights and patient empowerment (see, e.g., Cole et al., 2022; Timmermans, 2020; Vinson, 2016). Insofar as both of these foreground patients having a strong voice in their own healthcare

journey, it is pertinent to note that, insofar as they are not inhibited by the barriers and environmental constraints that nurses operate within, patient voices may become a strong call for change that can also be leveraged to incentivise institutional change.

5 | CONCLUSION

This paper has served to identify and map some of the complexities and pressures that both inform and destabilise the concepts and practices of caring—particularly PCC—within Australian nursing. As has been shown, the concept of care while seemingly at the heart of nursing practice has been professionalised— legalised—into a duty of care to the patient. In addition, the paper shows how ideals of care are dominated in practice by other pressures. Indeed, it almost seems that the constructions of nursing care that are written into PCC and PCP commitments have become overlaid with technical requirements for practice and risk management. That is, what this discussion has made clear is that many of the efficiencies that are desirable from the organisational perspective, work in direct opposition to the ideas and ethics of care that underpins nursing practice. This is the point that ideals of nursing care and of PCC have been eroded by the foregrounding of institutional and organisational efficiencies. Such devaluation is clearly visible in the practices of nursing care where, constrained by bottom line targets, nurses are pushed into a corner where care plans and strategies of manipulation are commonplace and overtake the delivery of customised care.

While these points are certainly problematic in the deindividualization of nursing care and practices that promote a 'tick-the-box' mentality, they have wider implications. That is, they mark a change in the identity construction of the nurse and of nursing practice. That is, it appears that the requirements of the nurse to have empathy, to care for the patient, and to provide individualised and tailored care have been replaced with a capability to perform mechanisms of care that are designed to produce time-efficient and commodifiable types of patient management. Despite the rhetoric of valuing and achieving individualised care visible in Australian nursing standards and codes, the actual operationalisation of nursing care marks a clear erosion of care that leaves nurses as perhaps no longer identifiable in the ways they hold as essential. At the same time, as we have outlined in the final section of this paper, these problems in the delivery of care can be traced back to a lack of institutional commitment to the delivery of all the dimensions of PCC. What must be recognised is that nurses themselves are not to blame for this inability to provide care in a genuine sense. As this paper has demonstrated there are multiple factors that influence the ability to be able to demonstrate and provide care. Institutions and healthcare providers will only invest in improving this notion of PCC if it is appropriately valued and measured, and when such measurement is mandated and associated with the ability to attract funding. This is a call to action for all health professionals, institutions and governing bodies to place the individual patient and their experience at the centre of healthcare in an attempt to provide genuine person-centred care.

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