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Being a woman, nurse, leader, researcher and employee in the hospital system – a mental Sisyphean task of massive proportions!

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Read the essay about:

Being a woman, researcher and nurse for 40 years

Inequality and discrimination

Crisis of care and nursing

What we can/should do about it

Introduction

Every day the media report examples of inequality in many different areas, both in society in general and in the healthcare system. It is a theme that concerns many people, including me.

This has led me to write the following debate & essay article about my own experiences and reflections regarding being a woman, nurse, leader, researcher and employee in the Danish hospital system.

In this essay, I will relate my own experiences to studies and the experiences of others, and I will offer some explanations for why it is so difficult to change a given practice and culture, even though you may want to.

I will conclude by describing what I believe is fundamentally needed for such change to be possible – namely the Willingness and Courage to change.

Sisyphean work

The concept of Sisyphean work is named after King Sisyphus from the Greek mythology, who as punishment had to eternally roll a boulder up a mountain, from where it would continuously roll down – a hopeless and never-ending task (Danmarks National Leksikon).

Two steps forward and one step back

I am a woman, nurse, researcher and research leader. Throughout my 40 years of working, I have experienced the different faces of inequality and have personally and professionally engaged with both the causes of inequality between men and women, discrimination between healthcare professional groups and the lack of care and humanity in the healthcare system. I have experienced many challenges throughout the years, both being unable to provide the level of patient care that nursing professionals know is needed, due to systemic constraints, and fighting for respect and recognition of my nursing and research competencies.

It has often felt like a Sisyphean task, or like taking 'two steps forward and one step back,' but giving up was never an option. The fight for respect and recognition - not just for myself as a woman, nurse, leader, and researcher, but for all who would follow - was far too important. And I remind myself: we are still moving forward, even if slowly, taking two steps forward and one step back rather than the reverse!

Caregiving crisis and nursing care

The growing body of literature on these themes confirms that I'm not alone in experiencing such inequalities. Recent months have seen a surge of publications addressing inequality and care in both healthcare and society at large, including: ”Lægen der gik ud for at lede efter medmenneskeligheden” (The Doctor Who Went Looking for Humanity) (Marså 2024),”Omsorg under forandring” (Care under change) (Tidsskrift for Forskning i Sygdom & Samfund, 2024), “Underskud-Om værdien af omsorg” (Deficit - On the Value of Care) (Holten 2024), “Ulighedens drejebog -Sådan virker social ulighed i sundhed” (The Script of Inequality - How Social Inequality Works in Health) (Larsen & Sodemann 2024) “Køn og karriere i akademia - Bag facaden ” (Gender and Career in Academia - Behind the Facade) (Järvinen & Mik-Meyer 2024).

These publications highlight how society and healthcare systems systematically undermine caring relationships, devalue women who provide care, and dismiss women and female nurses with academic and research backgrounds.

In nursing, this devaluation manifests in common political and societal rhetoric that reduces the profession to having 'warm hands' rather than recognizing the specialized knowledge and competencies nurses possess. This dismissive mindset suggests that the current nursing shortage can simply be solved by importing nurses from India and the Philippines, shortening nursing education, or requiring all nurses to perform specialized care regardless of their training level or position.

Yet nurses, like doctors, require specific education and training for complex specialty care - just as physicians cannot perform complex procedures without specialized training!

Inequality & differential treatment

My own experiences with inequality and discrimination, along with those documented in numerous studies, are too extensive to fully catalogue here. Instead, I will share four situations from my career between 1984-2024, focusing on professional hierarchies, misuse of power, discrimination, and neglect of care in healthcare practice. These examples reveal that despite various initiatives over the past 40 years, healthcare's fundamental inequalities remain largely unchanged. I will explore why addressing these obvious and unacceptable inequities proves so persistently challenging, even when their harm is clear.

The Nurse as the doctor's helper and "nice girl"

I graduated as a nurse in 1984 and joined a general medical department.

The culture was dominated by a rigid hierarchy with doctors firmly at the top - embodying the "doctors know everything" mentality - where a purely biomedical approach to treatment and care prevailed.

As nurses, we were expected to be the doctor's helper, following orders without asking questions – especially not critical questions. Many scenes from the TV series "Nursing School" mirror my experiences perfectly!

I witnessed how patients admitted for "causa socialis" [social causes] or elderly patients with chronic conditions were consistently given lower priority than other patients. This led our nursing team to sometimes "hide" patients during rounds to prevent their discharge. While they might have been medically stable, we knew they weren't psychologically, socially, or existentially ready to leave the hospital.

After 1 year of employment, I could no longer tolerate this culture, so I applied for a position as the head of a geriatric medicine department (Long-term care). This came to the attention of the male consultant and one day he came up to me and said:

> I hear you've resigned and want to go to the long-term care department instead - you have a pretty and clever head, and we doctors need that in this department, so why on earth do you want move to the hospital's least attractive department?

I didn't quite understand the seriousness and discrimination in the consultant's statement, but I remember thinking:
"Thank God I'm leaving here."

The first geriatric teams in Denmark

In my new position at the Department of Geriatric Medicine, I was given both professional and (partly) financial freedom to hire care staff who were passionate about providing geriatric patients and their families with compassionate nursing and care.
Our department fostered respectful, constructive collaboration across all disciplines and management levels, allowing us to take a holistic approach to patient care. We pioneered Denmark's first Geriatric Teams, bringing together doctors, nurses, and therapists to provide both in-hospital and outreach care.

The budget and measurable results before care

In 1995, the then head nurse (chief nurse) resigned and a new head nurse was appointed who, in accordance with the national New Public Management wave, focused more on finances and spreadsheets as methods to show measurable results than on the value and importance of caring relationships. This had major consequences for both patients and us as staff, as we could no longer maintain the person-centred and holistic culture we had practiced for 10 years.

The new chief nurse mandated that all patient care be documented in Excel spreadsheets, reducing care to purely physical measurements while ignoring patients' existential needs. This distinction went completely against our previous holistic approach to patients, which we as a united staff group objected to, but we were talking to deaf ears, and at a meeting she directly said:

> *I can hear that you disagree with my decision, but I am the leader and therefore I have the final say, and I say that we maintain the care burden measurements as the basis for calculating how much time you should spend with each patient.*

Many other cost-cutting measures were also implemented that were detrimental to patients' wellbeing, and I could not accept that I, as a clinical nursing professional manager, had to constantly make compromises with regard to my own professional values.When I got the opportunity to participate in a three-year research collaboration, and get leave from my position for three years, I seized the chance to step away.

Reputation and leadership power trumps evidence-based research findings

In the research project, I had the opportunity to research a theme that was important to the department and to me: how decision-making processes took place between doctors, nurses and elderly chronically ill patients – including what significance patients' own wishes for their course of treatment were given.
The research resulted in a research report entitled "Dialogen der blev væk" (The dialogue that got lost) (Kjerholt 2000). The two-year field studies revealed a predominantly biomedical and instrumental view of patients, which had the impact and consequence that patients' holistic needs were often not met.

I was convinced that the department management in the department where I was employed would relate objectively and professionally to the results and initiate development initiatives to change the current decision-making procedure – including the prevailing biomedical view on humans and patients.

But it didn't work out that way: Instead, I was called in for a meeting with the department management, who criticized me for publishing the results without them having read and approved them first. A step that I hadn't taken, as my research supervisors and research colleagues had validated my findings.

The management directly said that I was ***"hanging our dirty laundry out to dry in public"*** and even though I had been employed in that department for 15 years at that time, I chose to resign, as I felt there was no basis for a future equal constructive collaboration between the department management and me.

Lack of respect for and disregard of care work, nursing and the complexities of nurses' work

This was followed by 25 years where my nursing background, leadership, development and research went hand in hand with clinical hospital practice.

Despite many different studies in different settings that uncovered challenges with both recognition of and respect for nursing, nurses and their research, as well as challenges with ensuring caring and compassionate relationships with patients and in staff contexts, and also provided specific solutions to the challenges (Kjerholt 2004, 2011), these studies did not reveal significant or visible concrete changes in and of the practices studied.

A concrete example of the challenges and resistance I have described above can be seen in an op-ed written in 2021 by three doctors from a hospital department (Berlingske, 2021).
In the piece, they postulate that today's hospital system has:

> *.. employed an army of nurses - the so-called 'private duty nurses ... whose function is in no way clear to us. The nursing profession, with deputy directors of nursing, senior charge nurses, charge nurses, ward nurses, ward managers, development nurses, nurse researchers, quality assurance nurses, etc., is characterized by a large number of appointments that contribute modestly to daily operations but are extremely cost-intensive.*

They further postulate:

> *In recent years, hospitals have built up nursing research units with new appointments of nurses in professorships and research leadership positions, producing numerous writing whose content is reminiscent of the 1970s Master's theses from Roskilde University described in Berlingske (...).*

The quotes speak for themselves and speak volumes about the deeply disrespectful and condescending view some doctors have of colleagues and partners when they are women, nurses, managers and researchers!

Poisoned and abusive culture
I can add that despite massive criticism and responses to the doctors' offensive insinuations and postulations, as well as refutation of these from various bodies, both nationally, regionally and locally, there were no consequences for the three doctors' continued employment in the department, who can therefore still practice poisoned offensive behaviour and culture.

In the same vein, I can tell that several male doctor colleagues have often asked negative questions about me as a practice researcher and about my practice research, which they believe ***"cannot be called research, but only development".***
They argue that my research field is about the development of practice and that the research approach is humanistically based ***"...which is not real research...".***

Scientific arrogance
The negative statements can be taken as an indication that they neither recognize, respect, nor are open and curious to research approaches other than the prevailing scientific and biomedical research approach. Another word for this is one-sided scientific arrogance!

Confronting the old guard
Of course, not all doctors have this deeply patronizing and disrespectful view of women or female colleagues, and over the years I have had many equal and respectful working relationships with doctors where our common goal has been to ensure holistic and individual patient care.

These doctors also have negative experiences with such representatives of medical professionals of yesteryear, but as several of them have said to me, they either do not dare or are unable to speak up to these powerful players for fear of their own future career, or they have tried to speak up but to no avail, or they shrug them off and accept the behaviour.

As one of the doctors said ***"it's business as usual, so I don't spend my time worrying about it – I just mind my own business".***

On the face of it, this may be an understandable way to deal with problematic colleagues, but it can have disastrous consequences for both a department's and an organization's culture, as the following quote by Lars Behrendt nicely expresses (LinkedIn post, 07082024):

" Nothing kills a great employee faster than tolerating a bad one. If you want great company culture, start by getting rid of office politics, favouritism, bullying".

"Culture eats strategy for breakfast"
As I have already mentioned, there is a myriad of literature that both exposes gender inequality, professional inequality, inequality in academic and research contexts, neglect of care, and that healthcare is suffering. That is, there is no lack of knowledge or evidence about the existing problems. There is also a wealth of both international and national literature indicating possible solutions to the problems (McCormack et al 2021, Kjerholt 2004, 2011, 2021, Aaskov Falch & Danbjørg 2023, Holten 2024, Larsen & Sodemann 2024).

Structured ignorance
In other words, it is not a lack of knowledge and evidence, but a failure to translate this knowledge into practice that is the reason why the major inequalities in our society and our healthcare system still exist... so why aren't we translating existing knowledge into practice? Perhaps because there is too much at stake for the parties who are currently privileged, and thus have turned a blind eye to the obvious problems that exist in many areas, including in our healthcare system.
Some call the privilege blindness, others call it ***"epistemology of ignorance" or "structured ignorance".***

This covers the fact both a society and individuals can choose, either consciously or unconsciously, to ignore facts, inappropriate power structures, use of power and hierarchies for their own gain!

Denmark's first female prime minister and feminist, Helle Thorning-Schmidt (2021) describes gender inequality as follows:

> People who deny the gendered difference have an extreme lack of self-awareness, a total lack of understanding of their place in the world and the privileges they have. Being unable to see that others don't have the same opportunities as you do is the very definition of privilege blindness (My translation).

Should there be some readers who are still left with the impression that these are just "opinions", there is evidence to be found in the book "Køn og karriere i Akademia -Bag facaden" (Gender and Careers in Academia - Behind the facade", in which the two professors Margaretha Järvinen and Nanna Mik-Meyer, through interviews with 173 associate professors and professors, provide evidence that it happens.

The reason for maintaining the (inappropriate) status quo can also be your own blind spots, lack of courage or conflict aversion to change a given culture, or lack of competencies to initiate changes in and of practice. In regard to the latter, this can be learned, or you can hire someone who knows how to do it!

What can/should we do to reduce inequality?
The older I get, the more I realize that Things Take Time – not least when it comes to changing a given (hospital) culture with all its embedded hierarchies, power structures and favouring of natural scientific and economic values, but change IS possible if both politicians and healthcare professionals, both at management level and clinical practice level, have the willingness and courage to initiate such a cultural change. In a recent interview, the chairwoman of the Danish Nurses Organization, Dorthe Boe Danbjørg (Danbjørg 2024), states that:

> *At a time when priorities have to be set and healthcare is is greatly characterized by medical-technological development, we must also convince decision-makers and politicians that we can solve many of the challenges of healthcare with the help of nursing – if time is allocated to nursing and nursing is prioritized, that is.*

She further states:

> *In short, the message is that nurses must lead nursing activities and that nurses must be at the table when decisions are made about nursing, development and priorities in healthcare – at all levels.*

Inequality is not a natural phenomenon, but is created, maintained and nurtured by humans, so we can do something about it – if we want to! I would therefore like to end with the following appeal:

"Treat others as you wish to be treated"
Think about what kind of society you want to be a part of, and think about the social structures and values that both inhibit and promote such a society. Despite the Sisyphean nature of the task, my most important piece od advice is thus:

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