Newton’s cradle: a metaphor to consider the flexibility, resistance and direction of nursing’s future

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Nursing faces an uncertain future as technological developments, structural changes within health systems and rapidly evolving health needs create new and challenging possibilities. This article draws on the results of a qualitative study undertaken with a range of Queensland nurse leaders to explore their perceptions of these changes. The study resurfaced, and allows for a re-examination of, four issues that have long created tension within nursing and which continue to have a negative impact on the profession as a whole. These are as follows: professionalisation; preparation of graduates; myths and narratives of nursing; and leadership. We provide a metaphor that imagines all of these tensions operating in dynamic interplay. The image is that of a Newton’s Cradle – a model for energy and momentum. The metaphor allows one to see the wide context of changes affecting nursing and the significance of the interconnections. If tensions within nursing maintain their own integrity through containment, understanding and development, they remain in alignment, and energy is conserved rather than wasted or misdirected.

It suggests that with increased awareness and attention paid to internal challenges, and by taking a broad-based approach to systemic improvements, nursing could become more effective, progressive and proactive in shaping its own future.

Key words: change, future, history, metaphor, nursing, profession, technology.

Nursing does not have a crystal ball with which to see the future with certainty and know what challenges and opportunities it will face in the years ahead. However, just as the past can be useful in helping us understand the present, the present can provide some pointers as to what these may be and how well-prepared, individually and collectively, nurses are to face them. Over the past decade, the international literature has begun to speak of a turning point in nursing’s history (Yoder Wise 2010). The unabating health workforce shortage has prompted potentially paradigmatic changes to health services (Potempa, Redman and Landstrom 2009). Initiatives taken to address shortfalls include the creation of physician’s assistants (Jenkins-Clarke and Carr-Hill 2001); expanding the scope of practice of health professionals, including nurses and paramedics (Rushforth and McDonald 2004; Tervo-Heikkilä et al. 2008); creation of a third tier in nursing (Willis, Reynolds and Keheler 2009); and expecting carers and communities to increasingly shoulder the burden of care (Fagin 2001).

Although scholars and policy-makers may be aware of this state of flux, it is not clear how aware ordinary nurses are, or how they feel about them. Therefore, from 2009 to 2011, a mixed method study of Queensland nurses was undertaken to investigate these issues and to explore the perceptions of nurses regarding future challenges and to examine how well-prepared nursing is to face them.

THE STUDY

Ethical approval was obtained through the Human Research Ethics Committee of the lead author’s university. The qualitative phase of the project involved interviews with eighteen...
prominent nurse leaders across a variety of sectors: academic; public and private nurse administration; acute and community healthcare institutions. Following purposive sampling (Liamputtong 2010), these participants were approached by the research team because of their positions and likely insights into the issues. The interviews were all conducted by the same member of the research team, either via telephone or face-to-face, guided by a series of semi-structured questions. Verbatim transcripts were independently analysed by another two members of the research team using NVivo© software (QSR NVivo 9, QSR International Pty Ltd, Doncaster, Victoria, Australia). Categories and subthemes were compared before a general model was constructed to represent the major themes, namely affecting the future of nursing: professionalisation, preparation of graduates, and myths and narratives of nursing and leadership.

THE POWER OF METAPHOR

Metaphor is a figurative device which links concepts in surprising ways, making the strange familiar and the familiar strange. Metaphor offers potential to rethink concepts by pushing boundaries of conventional ways of thinking, and inviting imaginative, creative thought. Its open-ended, ambiguous nature can be utilised to discover new ways of thinking or to generate creative solutions (Lakoff 1987; Phillips 1998). It may embody or suggest meanings which resonate for those working within other frames of reference, thereby building unity and shared knowledge between otherwise disparate groups of people, and in the present case may speak to non-nurses about shared problems and potential solutions. Metaphor may also have particular local and personal meaning. To use the metaphor of the ‘builder’, for example, may suggest that nurses have a role in designing new ways of planning therapeutic interventions, laying the foundations for a therapeutic relationship, constructing meaningful interprofessional dialogue and cementing collegial relationships. Lastly, and perhaps most importantly, metaphor can reveal a positive perspective to a situation otherwise viewed as exclusively negative and can allow people access to complexities and nuances which would otherwise remain hidden.

NEWTON’S CRADLE ENCAPSULATING TENSIONS IN NURSING

A metaphor for understanding the tensions and uncertainties experienced by nursing and which have repercussions for the directions in which nursing is headed is the construct called ‘Newton’s cradle’ (see fig. 1).

Named after Sir Isaac Newton, this device is also known as an executive toy clicker (Newton’s Cradle 2013). Five rigid balls hang in a row with bifilar suspension, in such a way that they barely touch their neighbour. The device illustrates a number of physics principles, in particular conservation of energy, flexibility, resistance and energy transfer. The first ball is lifted up and let go; it hits the second ball and comes to an immediate stop, while the ball at the other end of the series rises into the air. When the system is ideal, the last ball rises to the same height as the first and no energy is lost, but when there is a lack of flexibility, internal resistance within the material of the balls, or friction between the balls, energy wastage occurs and the system is inefficient and ultimately ineffective. It is possible to imagine nursing tensions in this dynamic interplay as the balls in Newton’s cradle, and to see important tensions, impacting on each other (see fig. 2), rather than trying to understand each in isolation.

PROFESSIONALISATION: INTERNAL TENSIONS AND COMPLEX INTERPLAY

The professionalisation of nursing began in the mid-19th century and since that time there has been a tension between the professional objectives of nursing and the ‘industrial’ issues of wages and conditions (Reverby 1987; Dingwall, Rafferty and Webster 1988; Strachan 1996). Strachan’s (1996) history of the Queensland Nurses Union, originally the Queensland branch of the Australasian Trained Nurses Association, illustrates the historical roots of this tension very clearly.

In our study of Queensland nurses’ perception of changes affecting them, the problem of retaining nurses in the workforce was raised. For some participants, the professionalisation of nursing is actually at odds with, but tied to, its industrial structure. ‘Are we actually pulling the workforce...
back, or are we making it so much more industrialised we’re not really looking at the professionhood? … We’re going to be this really industrial model and how does that fit with the professional model (03).

This professional-industrial tension reflects nursing’s professionalisation being based for over a century on vocationalism and the belief that nursing could attain social and professional status through self-sacrifice and denial of material considerations, notably wages and employment conditions (Reverby 1987; Dingwall, Rafferty and Webster 1988; Baly 1995). This approach was useful when trying to justify 19th century middle class women taking up a social and public role. For most of the 20th century, however, women and men who became nurses have needed to earn a wage that supported them and their families (Madsen 2008).

The expectation has been, historically, that [poor wages and conditions are] part of the job, and you have to kind of just put up with it. Well, I think that these days, nurses aren’t prepared to do that … I think that that sort of lifelong commitment to nursing as a profession is probably a bit more ephemeral now than it was and I don’t see any way of changing that frankly (08).

It has long been recognised that the professionalising ‘project’ over the past 150 years had some significant flaws, not least of which being the need to secure wages and conditions for nurses commensurate with the work being undertaken. Nurses therefore spent a good deal of the 20th century fighting for these through unionisation and industrial campaigns, actions that were paradoxically seen by many nurses and by a large section of the community as distasteful, unethical and the antithesis of professionalism (Dickensen 1993; Strachan 1996). Ironically, for many of the nurses interviewed in this research, wages and conditions have become the measure of nursing’s professionalism, and few cited altruistic reasons for becoming or remaining a nurse. ‘We tried to make it a profession, but whether anybody likes it or not, nursing is being a nurse, doing the daily cares of patients’ (09). Another indicated, ‘I mean nursing is – it’s not a – not a particularly glamorous job. It’s jolly hard work … So we have to try and make it, not necessarily easier, but more palatable’ (16).

Nevertheless, despite gains made in relation to pay and conditions, some also expressed a belief that something is at risk of being lost through professionalisation, in particular with regard to how nursing is practised.

So our professional practice environment has to be established around what retains nurses … It is fundamental that we get workloads right for nurses and midwives because without that they can’t practise at the professional and expert level they want to or need to and further research will show that nurses will leave the profession if they cannot deliver the care to the level that they believe they have been educated to do so (04).

For these nurses, central to the professional-industrial tension is the notion of ‘care’ and how ‘care’ is embodied and practised in nursing. While the issue of care in nursing is examined further in the theme ‘myths and narratives’, it is worthwhile noting here that some nurses felt that the association between care and earlier idealisations of professional nursing have been undermined by arguing for better wages and conditions. Others suggested a concept of professional nursing which rejected the pivotal role traditionally accorded care and caring. What is clear and of particular relevance for this research, is that there appears to be no consensus as to where nursing should locate itself in this professional-industrial matrix. What is actually a complex problem, suffused with paradox, has been addressed as if it were a simple either/or question, namely whether nursing is a profession or an occupation, resulting in internal conflict and wasted energy. Failure to resolve this problem lies at the heart of tensions inherent in subsequent themes found in this study and is responsible for the dissipation of significant energy within nursing.

For nursing, professionalisation is imbued with struggle and exists as a powerful tension in its own right. Thinking metaphorically, however, reveals the position of this task within a complex web of long-standing problems, and shows it to be just one struggle among many, each impacting on the other, at times misfiring, colliding, pulling in different directions, and causing energy surges and wastage.

**PREPARATION OF GRADUATES**

One complex set of forces with which professionalisation interacts is nursing’s educational system, and in Australia,
This is still coming to terms with the transfer to the tertiary sector some 25 years ago. How nurses perceive their work within the professional-industrial matrix influences their opinion of ‘nursing knowledge’ and the education required to prepare registered nurses. Here, the tension principally revolves around practical and theoretical knowledge, and between informal and formal learning, again conceived largely as simple dualisms. Much of this tension is driven by the stance taken towards the apprenticeship model of training, and the move to universities for nurse preparation which was completed in Australia by the early 1990s. A number of the participants in this study revealed a yearning for a return to practice-dominated ‘training’. Their comments suggest that they not only view the practical over the theoretical, but seem to believe the system they had themselves experienced provided a better preparation for nursing. ‘I just think it’s so removed from reality now. It’s not like when I did mine. The educators would come and work with us’ (09). Another suggested, ‘So the model that we had is the wrong model, bringing people in and putting them in a little white tower in academia and de-skilling them as nurses and then getting them to teach’ (16).

Others acknowledged that the shift to university had been beneficial, although they believed that the balance had not yet been struck and that more clinical time was needed to ensure students were ‘work-ready’ when they graduated. It is not clear whether this was based on an accurate knowledge of the actual clinical times built-in to current courses, or an expression of a popular belief as to their inadequacy in this regard.

Some participants also saw a differentiation in nursing roles as offering a way forward.

There is probably a place, for example, for a group of nurses to be trained in the old style, where they used to actually get employed by hospitals and their education [was acquired] as they worked. And there is probably a place for a group of nurses who are going to be hospital-based nurses to potentially do that. And then there is another group who have a, say, a more academic role and it may be to some extent that their training should be a little different (07).

There were also a number of suggestions to bring the academic and clinical roles closer together by either having more clinicians involved in delivering education or in having academics undertake a clinical load.

Clearly, there’s many other components to an academic role apart from the teaching. But in the teaching stuff, I suspect that we will need to see a greater blend of using practitioners in a complementary way to faculty, in training (10).

So I have said for many, many years that providing nurses with a clinical loading, providing academic – nurse academ-
I think we’ve been too narrow and we’re too hospital-centric… and the other thing is, there’s a culture in nursing I believe that everybody’s got to be experienced… are we holding nursing back by trying to be as we’ve always been, but just modernise it a bit? (05).

So it’s not seen really as an option and maybe people feel like they’ve got to come and do the hard yards in acute care first… I think we have a lot of trouble letting go of illness care … and I think a lot of that has come out of all that historical stuff – the doctor’s handmaiden thing and then the struggle to be seen as professionals in our own right (11).

The second narrative emerging from the data related to the old adage that ‘nurses are born, not made’, and that caring is an inherent trait of nurses and in some sense exclusive to them. ‘You don’t train someone to – I don’t think you can train somebody to be caring if they’re not initially’ (01). Another revealed, ‘I think ideally you shouldn’t have to be trained to care. You should just care… it should be one of the factors that drives you into the profession in the first place’ (05).

Caring is still regarded in the minds of the public and nurses alike to be the very essence of nursing. This creates a number of significant dilemmas, however, because there is no consensus as to the meaning of ‘care’, and there is a barely concealed implication that other healthcare workers are less caring. It is sometimes linked to older notions of compassion, consistent with philanthropic ideals prevalent in the professionalising discourse of 19th century nursing, while others understand ‘care’ to be revealed through competence, a notion that is rather more consistent with knowledge-work (Nelson and Gordon 2006). Participants in the present study revealed a general dissatisfaction with the concepts of care most frequently found in nursing discourse.

People think caring is all soft and warm and fuzzy but it actually means clinical competence. It means making rational judgements (11).

Well I mean that whole notion of care being the central for nursing; nobody has ever been able to really define what they mean how care in nursing is any different to any other type of care. I guess it’s one of those words that we just use all the time and I think in a sense greatly devalues what nurses do. Caring is seen I think in very much less valued than some of the other aspects of curing. I think it’s seen very much in that sort of servant-hood type notion (15).

Again, it is not clear exactly how well versed the interviewees actually are in the vast and sometimes very sophisticated discussions of care and caring in the nursing literature, but their comments clearly reveal the ambiguous, paradoxical and problematic role these play in nursing. Their view is consistent with that of Nelson and Gordon (2006) who suggest that, despite the scholarly literature, nursing needs to reframe the concepts of care and caring in the light of contemporary circumstances in order to create greater self-understanding as it moves into the future. This may help nursing to be more effective in directing its energies towards future challenges.

**INTERNAL TENSIONS IN LEADERSHIP**

Leadership has not traditionally been encouraged within nursing, despite a history of working within hierarchical structures. Those who endured the system long enough and found themselves in management positions, often also found themselves in leadership roles for which they were rarely prepared. Nursing’s academic literature increasingly promotes concepts of democratic or transformative leadership, based on role modelling, collaboration, shared goals and nurturance (Thyer 2003), but in practice, its leaders are required to adopt the hierarchical style of the organisation, impose its demands on the workforce, exercise a regulatory and disciplinary function and employ a strategic way of engaging with colleagues. Leaders, particularly those at middle management levels who interface with clinicians, are thus in a conflictual position in which they are required to pursue the ideology of the system but at the same time respect the values and preferences of nursing (Stewart, Holmes and Usher 2012). Nursing leadership in the health system continues to contribute to a culture of subordination and obedience, and participants in the present study took the view that this will need to change if it is to become effective. ‘We still have got a lot of nurses who work in hierarchical thinking, which is tradition, like as in military thinking. We can’t continue to have that thinking… So it is about really thinking about our practice and our leadership’ (15).

However, the nurses who were interviewed, despite being in leadership positions themselves, did not have clear notions of their own leadership or the potential for nursing contained in these roles.

We can learn a lot from great nurse leaders and other groups that you interact with of the 80s that did a lot of lobbying, were very articulate but they had a really clear vision and could articulate where nursing and midwifery were going, mental health nursing… And I look now and I said to someone the other day, and this is probably a personal reflection, is that we are the leaders now. And if we actually do not take the time… it’s about having the good critical debate and different thoughts, so that energised conversation and a vision that is the future can actually be developed (03).

The difficulty appears to relate to these nursing leaders being focused almost entirely on the problems and issues of
their own institutions and not being able to shift the vision to a broader context and consider the profession as a whole.

Of course, we think about it but we think about it, of course, in the context of our own situation and our own services. So that’s quite challenging to … think about the whole profession and how that might play out over the next couple of decades (10).

The profession as a whole still has not yet said, ‘What is the future of nursing?’ And you don’t see many places looking at the nurses of the future. It’s all – it’s very catch-up stuff (16).

Part of the difficulty in shifting this vision relates to a lack of avenues in which the necessary conversations can take place. In the past, strong professional nursing associations provided such forums. In Queensland, for example, the Queensland branch of the Australasian Trained Nurses’ Association met regularly, attended by those interested in the future of nursing as well as those who held positions of authority (Strachan 1996). However, this association gradually changed its focus and today is the union that represents nurses for industrial issues. There is a national professional association but no local branches, and overall few nurses are involved in the sorts of conversations or activities that focus on these fundamental questions: what is nursing and how is nursing positioned for the future?

Another aspect of the difficulties revealed in this theme relates to a perceived lack of preparation for nurses assuming senior positions and of exposure to ways of thinking that promote effective leadership within nursing.

But unless we have professional accountability and lifting the capacity of our workforce, we are not going to succeed… So to me, the capacity of our workforce needs to change. We have got to get people out there who have got untapped capacity, and it is about engaging them into enabling them to be leaders in the future, that sort of stuff. Getting them prepared to be a leader of the future, instead of dumbing them down (05).

But sometimes I think we should use our influence more and be more professionally active. We’re probably always relying on somebody else to do that… Leadership is about developing relationships and trust and credibility (03).

The participants recognised that leadership was not only associated with particular nursing positions, such as in administration, but was also expressed through nurses taking charge of their own practice and that this was something all nurses should be striving to do. This would provide the nurturing ground for developing stronger leadership in those roles which have a more visible public face. Curtis, Sheerin and de Vries (2011) have recognised this lack of leadership development in Britain and suggest that universities and healthcare organisations can do much within their programmes to develop leadership skills and practices. In Australia, for reasons noted above, there has been an increasing awareness that leadership preparation should be high on the agenda, and a number of initiatives have been trialled, including national support groups, postgraduate university leadership courses, national and international workshops and conferences, dedicated scholarships, and international educational opportunities (Jackson, McDonald, and Wilkes 2011; AQNL 2011). The present project suggests that these initiatives will be essential if nursing is going to be able to draw together the energy and shared vision required to address future challenges.

A vision for the future of nursing is fundamental to nursing leadership, but was usually seen by the participants interviewed in this study as notable by its absence, at least as it concerns Australia. Unsure themselves as to the direction that nursing is taking, they lacked any clear vision as to its future.

I do think that there has not been enough planning and commitment to the long-term of where this workforce might sit, what the needs are in terms of levels, education, models of care. So I think at the moment, we’re spending too much time on the here and now, and I really think that we need to be looking at the next period, sort of five years and beyond, to be perfectly honest (05).

Well I’ve spoken a little bit about nursing – nursing futures and I guess this is, probably thoughts of mine, is that there isn’t much on in the way of – of a group to focus on nursing futures and maybe there should be something established (16).

A detailed analysis of the published literature, conducted as part of the present study, supports this view. It reveals that nursing is facing an accumulation of difficult choices and major challenges, and how it responds will significantly affect the form that nursing will take in the next decade, if indeed, it survives as a recognisable entity. Australian literature has not discussed the needs of nursing as it faces the 21st century, almost unanimously assuming the permanence of a traditional model of healthcare delivery, and rarely mentioning alternatives. There has been no assessment of the wide range of factors that are driving change in health-care, no consideration of the likely impact they will have over the next decade and therefore no articulation of evidence-based pathways to possible futures. In short, the literature offers no vision for the future of nursing in Australia, either as a passive object responding to change, or as a proactive participant in creating its own future. In a rare criticism of nursing leadership in Australia, Conrick et al. (2007, 53) warned that ‘… nurs-
ing desperately needs leadership and politically astute leaders to proactively take it forward if it is to exist at all in the year 2020. And yet, it is surely the responsibility of all nurses to consider and engage in the sorts of conversations that help shape the future of the profession of which they are part. This research suggests that the lack of discussion about the future of nursing is the direct result of the dissipation of energy nurses expend on dealing with insoluble, dualistically conceived questions concerning the definition of nursing, what its foundational values should be, and how nurses should be prepared.

**DISCUSSION**

Thinking metaphorically proved to be the most productive approach to analysing the data. A significant finding was that nursing in Queensland, perhaps indicative of other regions, is grappling with four major themes in isolation; but, when they are considered alongside each other, at times interacting, connecting or colliding, like the forces in Newton’s Cradle, a larger vision emerges. Our analysis suggests that an awareness of this larger vision is a precondition of nurses, individually and collectively, becoming effective agents in the construction and control of their own future.

Whilst changes are taking place, it is becoming evident that nurses are not necessarily prepared for them, nor ready to embrace new practices and ways of thinking. Research suggests that nurses in the UK and United States are becoming less motivated, energised or satisfied by their current realities and practice obligations in increasingly challenging circumstances (Ulrich et al. 2005; Ball and Pike 2009). US studies report that many nurses indicate a sense of being overwhelmed by the breadth of health system development and the complexity of the problems (Vonfrolio 2006). Lack of control over clinical practice, an inability to contest regulations, rules, accreditation and accountability demands, increasingly ‘draw the life and energy from each practitioner until little remains except for the intent to do what one can within the context of a narrowing scope of perceived opportunity’ (Roman 2006, 18). Disaffection and lack of commitment to nursing as a life-long career is also occurring in Australia and can be expected to increase as the workforce begins to rely more heavily on post-Baby Boomer generations, whose values and expectations are different from those of their predecessors. Health services and the nursing profession have so far failed to formulate the radical response which this is demanding.

McKenna, Keeney and Bradley’s (2004) British study supports the view that the culture of nursing, long developed and tending to foster acquiescence rather than leadership, and acceptance rather than critical questioning, will not allow an easy shift towards nurses assuming a more significant leadership position within the healthcare team. The study by McMurray and Williams (2004) illustrated that even when the management structure has been altered in such a way as to create the potential for greater innovation and involvement by nurses, many in leadership and management positions continue to feel they have been left out of decision-making processes and are not encouraged to be innovative. Unless conscious preparation and careful reflection occurs immediately, the nursing profession is unlikely to respond appropriately or confidently to the challenges ahead. Given nursing’s history, this lack of confidence is likely to trigger defensive positioning, creating considerable conflict and angst among nurses, and exacerbating the internal fractures that reproduce division, disunity and a fragile professional identity. It is also beyond doubt that nurses will be required to respond to pressures which will remain outside of their control, and this too will contribute to a lack of confidence.

Where role clarity exists, exchanges and interactions between diverse healthcare workers are likely to create stability, but when roles are changing, the state of flux can be destabilising. Exploring and investigating how nurses are responding to these changes can lead to deeper understanding of the experience of change and enable the generation of solutions that can be put into place early and thus minimise anxiety and create security. This is important because if nursing is going to respond in a positive and proactive manner, rather than in what many would call the traditional reactive way of the past (Donley 2005), they will need to reframe the way they think about their practice in order to be prepared for change and to enable them to act as decision-makers.

Using the analogy of Newton’s Cradle, it becomes possible to stand back from the individual tensions affecting nursing, to see the wider context and the significance of the interconnections. Newton’s Cradle provides a physics-based understanding of what happens when forces collide. If forces or tensions within nursing each maintain their own integrity through containment, understanding and development, they remain in alignment, and energy is conserved rather than wasted or misdirected. The metaphor helps to explain the impact on nursing of external events and illustrates how failure to attend to lingering internal tensions that affect its cohesion leads to energy wastage and poor outcomes. Increased awareness and attention to internal challenges, and a broad-based approach to systemic improvements will enable nursing to become more energy efficient and progressive.

The analogy with Newton’s cradle facilitates consideration of the interactions between the domains in which the tensions reside. The professionalisation of nursing over the
past 200 years has provided many opportunities, but it has also been distracting and has destabilised what many have considered to be foundational beliefs. Accumulating and releasing roles require identity adjustment and a strong sense of professional security. Yet without a clear and agreed identity resulting from professionalisation, it is difficult to make discerning decisions about the merit in this role shifting. A profession traditionally has clear external and internal identity, and established boundaries, is self-governing and can claim its own knowledge-base. Yet nursing’s continual struggle with these criteria has contributed to a lack of certainty and confidence which impacted on its ability to respond constructively to challenges, such as new approaches to the preparation of graduates in the 1980s.

Furthermore, the insecurity of nursing’s identity is exposed when nursing roles and practices shift because although a nurse is defined as a person who has passed a three-year education programme and is registered to practice, a nurse is also someone who assists registered nurses and who provides body care to patients. This terminological confusion is compounded by the perpetuation of myths and narratives of nursing that are produced and reproduced in public discourse and may still be driving current public policy. In some states of Australia, there is a minimum nurse: patient ratio, for example, but this ratio is based on the assumption that the ‘nurses’ are registered nurses, and so, it rarely exists in hospitals today. Even though nursing has changed, the myths and narratives have not. Finally, as the nursing and healthcare systems fall further into uncertainty, nurses are looking externally and often upwardly for leadership to help relieve the chaos and are finding nothing, and no one, there. Participants in the present study viewed leadership as a quality belonging to someone other than the ordinary nurse and were dismayed by what they saw as a dearth of good leadership in senior positions. The myth of iconic nurse leaders, following in Nightingale’s footsteps, continues to haunt nursing, and there is a sense in the literature that nurses are awaiting her second coming in order to save the profession.

The lack of energy that remains within nursing to determine its own future strongly indicates that past conflicts and unresolved issues are churning, diffusing and redirecting the energy of the nursing profession to the point of inertia. Consequently, nursing is not moving towards a preferred future, not happy with how it is being led, unable to conceptualise its own position within the healthcare system, and continually being impacted by external forces, and shaped by the needs and wants of others rather than controlling its own destiny. While the metaphor of Newton’s Cradle helps to show that nursing is impacted by a wide range of external pressures such as government policies, economic restraints and social changes, continually necessitating immediate adjustments and realignments, this should not be used as an excuse for failing to put one’s house in order. The internal tensions within each of the themes presented above, which interact within a complex web of forces strongly influenced by the past, indicate that nursing has not yet worked out how to manage the dilemmas arising from its dual professional and industrial status, or the tensions between clinical practice, theoretical knowledge and educational preparation; it has failed to understand its past ideology and its relationship to present reality, and it has been unwilling to accept the responsibility and accountability entailed by leadership. For these reasons, it has been inefficient in its use of the energies and talent within its ranks and unable to clearly focus on its future.

**CONCLUSION**

Imagining nursing as a dynamic entity affected by overlapping external and internal forces, suggests that these forces, and the tensions they create, need to be understood together as a precondition of productive reform. As the tensions continue, they produce energy that is diffused and wasted, when they could be propelling nursing forward into a preferred future. The metaphor of Newton’s Cradle helped illustrate this complexity and dynamic interplay. Perhaps the device may assist nurses who are interested in shaping or redirecting the future to think creatively, shift perspective and see different potential solutions. Rather than advocate for either professional advancement, or educational reform, this imagery analysis reveals the importance of valuing the development of the collective, of nursing knowledge, of nursing’s representation and the leadership potential within all nurses.

The past must be understood and honoured, and it is evident from this article that many of the inherent tensions in nursing have resulted from unresolved issues of long-standing. If nurses are to take control and responsibility for their own future, they need to come to some sort of consensus on: what it means to be a nurse in the 21st century; what preparation this nurse may require to be able to enter the workforce; how the work of nursing is to be organised; what role nurses should have in deciding their own future; and how that role may be fulfilled.

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