MEDICAL PRACTICE

Nursing Grievances

I: Voting with their feet

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Two Decembers ago one London hospital ward was unable to find its Christmas decorations. Not one nurse was still working there from the year before. An annual turnover of 100% may be disruptive, but at least it allows wards to remain open. That was back in 1986, when high rates of turnover could still be perceived as a problem. Since then the game of musical chairs that passes for nursing manpower planning has speeded up. When the music stopped in 1987 the shortfall between nurses and vacancies had never been greater. Some wards have always been difficult to staff: last year nowhere was spared. Even those most emotive of areas—leukaemia units,¹ dialysis units,² and paediatric intensive care^{3,4} were closing beds and refusing admissions. For short periods some even closed completely because of shortages of nursing staff.⁵ This Christmas in many wards in many hospitals they were searching for more than just the decorations.

Who would have thought even a year ago that when the crunch came in the National Health Service it would have come with nurses? It is really only their absence that many doctors have noticed: nurses have always seemed to be there, providing an inexhaustible supply of hands to be kept busy for the years between school and marriage. But no longer. Even “top” nursing schools are scratching around for applicants. Many who start are leaving before their training ends. Those who qualify and stay do so for shorter periods, their morale lower now than at any time in living memory. “Crisis,” for once, seems the right word.

Paradoxically this is happening at a time when nurses have probably never been held in higher esteem by the public,⁶ pay has never been better (both in real terms and when adjusted for inflation), and at least since the 1930s job prospects for school leavers in most of the country have never been worse. What has gone wrong?

The nurses I spoke to during the past six months offered several explanations, which form the bulk of this series. Future articles will

“Doctors don’t want to know, and they’re going to get such a shock. What I envisage in about a year or 18 months is a teaching hospital somewhere waking up one morning and finding one nurse in this ward and one nurse in that ward, and two there, and a couple in outpatients—and they won’t be able to get any more. There will be real crisis. People say why don’t you strike? What striking would mean is that you’d only be nursing emergency patients—which is exactly what we’re doing now.”—SISTER

look at nurses’ pay, conditions, professional status, and career structure; how the public’s perception of nursing affects these; and how nurses in other countries have set about improving their lot. This article attempts to give some idea of the scale of the problem.

To make sense of this and future articles readers will need to be conversant with a few facts about nurses’ education, statutory and professional bodies, and trade unions. Details of these are provided at the end of the article.

Going, going, gone

About one million people work for the National Health Service, half of them nurses.⁷ Nurses’ salaries account for 22% of the total expenditure on the NHS (or 2% of all general government expenditure). To raise nurses’ salaries by 1% would cost £43m a year. The cost of training the NHS’s complement of nurses at current prices is at least £4000 million.⁸ It is surprising that so little is known about any resource, human or otherwise, which is worth so much. Information about the numbers moving into and out of nursing and their reasons for doing so is hard to come by. The most recent nurses’ review body had cause to complain: “The lack of comprehensive and up-to-date data has been particularly regrettable this year. The anecdotal material which has reached us from various sources strongly suggests that there have been significant changes recently in the manpower situation, but there are no

statistics to give a reliable picture of what has been happening.”

Only as manpower shortages have increased has the subject attracted much interest. Three recent questionnaires give an idea of attitudes over the past two years (see table). About half of those questioned had “considered” or “seriously considered” giving up nursing in the National Health Service in the preceding 12 months. The best estimate of how many qualified nursing staff actually leave in one year (from surveys carried out by chairmen of regional health authorities) is 10%.¹³ This figure does not include involuntary retirement or movements within the NHS. Most nurses leave before the age of 30, never to return. In the past some of the gaps have been made up by agency staff, in many cases nurses already in full time employment in the NHS. Until recently equilibrium existed. In September 1986, however, the Department of Health and Social Security discovered that nationwide the number of qualified staff employed fell short of the funded establishment by 9%. In health districts in inner London the shortfall was 20%.¹³

The DHSS does not routinely collect figures on nursing vacancies and more recent figures than September 1986 have come from confidential staffing documents leaked to the press. These suggest no improvement since then and some deterioration. Vacancies for trained staff in London have been estimated at between 20% and

25% for most of 1987.^{14 15} A national survey by the Royal College of Midwives of the staff midwife grade in September 1987 showed 17.6% of jobs unfilled (the figures for September 1985 and 1986 were 14.0% and 15.2% respectively.) Units everywhere have had to cut services because of shortages of nursing staff. In the three months from August 1987 newspapers reported ward closures and bed losses directly attributable to shortages of nurses in Northern Ireland, Scotland, Wales, and every regional health authority in England.¹⁶

Recruitment

Why do these vacancies exist? One explanation concerns recruitment, which is certain to become of even greater importance in the not too distant future. The “easy come, easy go” model of nursing manpower, like the manpower model adopted by first world war generals, depends on high recruitment (fig 1). The problem is that fewer nurses are applying to go to nursing schools, and fewer are entering training.¹⁷ From 1981-2 to 1986-7 there has been a reduction of 29% in the numbers of those entering basic nurse training in the United Kingdom (fig 2). Once accepted for training 21% of nursing

Recent surveys of nurses' views

(1) 2041 nursing and midwifery staff (November 1985)¹⁰

Reasons for low morale (%): 82% of respondents

Cuts in NHS	76
Staff shortages	76
Salary	61
Increased workload	60
Changes in management structure	43
Other reasons	24
Privatisation of ancillary services	21

Reasons for considering leaving (%): 59% of respondents

Low morale	84
Pay	74

Stress	65
Other reasons	22
Policy of community care	14
Accommodation	8

(2) 2737 members of RCN (June 1986)¹¹

Percentage seriously considering leaving (in past 12 months):	
NHS nursing	32
Nursing altogether	8
Percentage already left NHS	14

Reasons for considering leaving (%): out of 29 options

1 Stress too high	71
2 Workload prevents giving of best	69

3 Bad atmosphere at work	68
4 Constant struggle with underfunding	59
11 Wanting higher standard of living	43

(3) 1025 members of RCN (September 1987)¹²

Reasons for considering leaving (%): 54% of respondents

Low pay	65
Not enough resources	61
Inconvenient hours	40
Poor job prospects	31
Personal reasons	10
Don't like nursing	3

students and pupils do not join the NHS (13% discontinue training, 2% fail their exams, 2% pass their exams but fail to register, and 3% register but do not join the NHS).¹⁸

The problems with recruitment are expected to get much worse. Nursing is the single largest recruiter of young women school leavers with between five "O" and two "A" levels. In 1986 the NHS recruited 17 000 of the total output of 70 000. By 1992 the total pool of school leavers will have dropped to 53 000. At its present rate of recruitment the NHS would need almost a third of this group.

Allowing for some limited growth in the number of nurses employed and an increase in some of the professions allied to medicine, the NHS would have to recruit nearly half its traditional labour pool.¹⁹ (By 1995 Wessex has calculated that it will have to recruit 87% of school leavers with these qualifications.²⁰) Competition already exists from other employers who are offering this group better salaries and conditions than nursing—for example, banks and building societies—and this competition is expected to increase over the next decade.

Qualifications and organisations

Education

There are two types of qualification for basic general nursing: registered general nurse (previously state registered nurse or SRN) and state enrolled nurse (SEN).

At least five "O" levels are required for entry on to the three year course for registered general nursing. Training costs (net of service contribution) about £12 000. There are no statutory requirements for pupils who enter the (usually) two year course for state enrolled nurses, although most nursing schools ask for two "O" levels and "a good general education." Training costs (net of service contribution) are about £6000.²²

There are three other branches of nursing: mental nurse, nurse for the mentally handicapped, and sick children's nurse. The first two branches resemble general nursing with similar entry requirements, length of training, and divisions into two levels: first (registered) and second (enrolled).

The SEN grade was introduced in 1943 as a wartime solution to shortages of trained nurses, but the grade is still around: state enrolled nurses and pupils comprise 20% of the nursing workforce. Many applicants were recruited for SEN courses from Commonwealth countries, particularly the West Indies, in the 1960s. What these newly trained nurses discovered, however, was that there was no progression beyond the SEN grade and problems with recognition of their qualification by other countries.

State registration is required for progress up any hierarchy or acceptance on to courses for further specialisation. The current two tiered system is seen as threatening progress towards professionalisation and, although no official decision has been taken to abolish the grade, fewer nursing schools are offering SEN courses. Some conversion courses do exist to allow state enrolled nurses to become state registered nurses, although too few so far for the available candidates.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC)

The UKCC (the nursing equivalent of the General Medical Council) has been responsible for the regulation of nursing, midwifery, and health visiting since it replaced the General Nursing Council in 1983. Its main functions are to establish and improve standards of training and professional conduct for nurses, midwives, and health visitors. In the fulfilment of this function the council formulated Project 2000. The council also maintains the register of qualified nurses, midwives, and health visitors (which currently stands at 546 000). Much of its day to day business is devolved to four national boards.

Royal College of Nursing (RCN)

Founded in 1916 (as the College of Nursing) the RCN with 265 000 members is now the ninth largest union in Britain and the fastest growing. In recent years the RCN has become much more "political." In 1960 it finally admitted men to its ranks: they now comprise 7.4% of its membership, and men fill four out of its top five administrative positions. Membership was extended to student nurses in 1968 and to enrolled and pupil nurses in 1970. Nursing auxiliaries may not join.

Routes into nursing.

Confederation of Health Service Employees (COHSE)

COHSE results from the amalgamation in 1946 of the National Asylum Workers' Union and the Poor Law Workers Trade Union. Its members come from all parts of the health service: two thirds of its 220 000 members are nurses. COHSE's heartlands were the large psychiatric hospitals, many of which are closing. Recently COHSE has become much more active in community care.

National Union of Public Employees (NUPE)

Formed in 1888 NUPE has 80 000 nurses out of a total membership of 660 000. There are other members from the health service and from local government, universities, and the water services. NUPE's nursing members tend to belong to the lower paid groups: state enrolled nurses and auxiliaries. NUPE was very active in the NHS pay dispute in 1982 and has been the union hardest hit by the government's plans to privatise catering, domestic, laundry, and portering services.

Retention

Some vacancies, particularly for skilled nurses, occur because of "poaching" by the private sector. An estimated 1000 nurses left the NHS for this sector in 1985,²¹ and with the increase in private medicine since then this year's figure will be higher. Three

Total numbers entering basic nurse training between 1981-2 and 1986-7 in the United Kingdom.

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in four of the nurses had some specialist training, all of it paid for by the National Health Service. In recent years increasing numbers of trained nurses have been recruited from Britain by other countries.

Vicious circle

The sequence that runs poor morale, "seriously considering leaving," left is, of course, not limited to nursing, but what is currently happening in nursing is that this sequence has turned into a circle.

Persistent staff shortages of 20-25%, for whatever reason, mean an increased workload or "stress" for the staff who remain, which in turn affects morale. Eventually more staff leave and the workload increases further. The same thing can happen if better staff complements are being maintained with a high proportion of agency staff, who may be on the ward for only a single shift.

For any improvement in the nursing crisis this circle needs to be broken. In the next article I will discuss pay.

WORDS IRIS. The miracle and splendour of the rainbow, its intangibility and its silence, cannot have failed to imbue our remote ancestors with a sense of communion with the deity.

And God said unto Noah, "I do set my bow in the cloud, and it shall be for a token of a covenant between me and the earth."

The ancient Greeks, too, regarded it as a sign of divine intervention. Iris was the messenger of the Gods and the rainbow was her sign. Hence, *iris* is Greek for rainbow. The rainbow was demythologised by de Dominis, who in 1611 explained the optical principles underlying its manifestation. These were further developed by Descartes, and the colours were explained by Newton. It is the great variety of colours found in flowers of the genus *iridaceae* that is responsible for the botanical epithet *iris*. Incidentally, *orris* (a corruption of *iris*) root, made from the dried rhizome of certain *iris* varieties, is an ingredient of some toilet powders, but has declined in popularity because of its allergenic potential. It has a fragrant violet-like aroma. The metal iridium was so named "from the striking variety of colours it gives, while dissolving in marine (hydrochloric) acid."

The iris of the eye seems to have been so called from the variety of colours that are to be seen in different individuals. *The Oxford English Dictionary* quotes Jerome of Brunswick's *Surgery* (1525) (translation): "There be iij materyall circles y' ronne about the iye and because they be so different of colours they be callyd yride(s) or rain bowys." It is tempting to assume that the iris was also so named from the resemblance of its roundel to the arc of the rainbow. But one would be lucky to see anything approaching even a semicircle at dawn or sunset, and in flat countryside. A complete circular rainbow, however, would have been a rarity and visible only from mountain tops; nowadays, of course, from aeroplanes. Does the individual iris change colour? Some people believe that it can do so under the influence of emotion.

It is perhaps conceivable that contraction of the pupil in a grey iris might disclose a deeper layer of blue between the fibres. If so, then exposure to light should do the same. This may be just a popular myth. The anatomical iris has the same or closely allied name in most languages. As well as *Iris*, German has the alternative *Regenbogenhaut*, literally "rainbowskin." Hence, the surgical instrument, the iridectomy, may be either *Iridektom* or (take a deep breath) *Regenbogenhautausschälungsmesser*. This is merely six words joined together.

Imitating the action of the iris of the eye, the iris diaphragm of the camera lens maintains a circular central hole of variable size. It was first used in cameras in the mid-1880s. But a similar device was invented by Robert Hooke, that most ingenious of English experimenters and inventors. In 1662 he was appointed curator of experiments to the Royal Society, and was under contract to demonstrate new experiments every week. The Royal Society's records for 27 July 1681 state, "Mr Hooke shewed his new contrived aperture for long telescopes, which would open and close just like the pupil of a man's eye, leaving a round hole in the middle of the glass of any size desired; which was well approved of." Good for you, Robert!—B J FREEDMAN.

Correction

ABC of Dermatology: rashes arising in the dermis

We regret that an error occurred in this article by Dr P K Buxton (21 November, p 1332). In the box on causes of "toxic" erythema the section on infections should have read: "any recent viral or bacterial infection such as streptococcal throat infection."