Nursing Grievances

IV: Not a profession, not a career

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No *man*, not even a doctor, ever gives any other definition of what a nurse should be than this—"devoted and obedient." This definition would do just as well for a porter. It might even do for a horse. It would not do for a policeman. . . . It seems a commonly received idea among men, and even among women themselves, that it requires nothing but a disappointment in love, or incapacity in other things, to turn a woman into a good nurse.

FLORENCE NIGHTINGALE¹

Many of today's doctors would argue that their Victorian predecessors had hit the nail on the head; few nurses would not bristle with the same indignation as Ms Nightingale. Who is right or, more fundamentally, who has the right to decide?

The road to professionalisation

Nurses have no golden age to look back on. It is to a glorious future that they look and against which they measure their present and find it wanting. Dominating this vision of their future is the enhanced status granted only to "true" professionals—much of nursing's history reads as an arduous struggle for respectability with many of the contortions nursing has put itself through explained by its desire to distance itself from any activity that smacked of trade.² Until recently "industrial" action was even further beyond the pale. But if a profession is defined as a self controlling occupational group with a particular skill for which it has been granted a legal monopoly then nursing still has some way to go. How can nursing improve its status?

Figure 1 deals in fairly crude stereotypes—not all nurses are women, or doctors men; doctors may not "cure," or behave any more rationally than nurses. Nurses do not need convincing how spurious these stereotypes are, but they do have to live in a world that currently subscribes to them. The main professionalising strategies open to nurses are either to stand firm and argue for a reevaluation of their role or to change their role by adopting one or more characteristics accepted as "professional."

STANDING FIRM

The strategy of standing firm is the most radical and therefore the most difficult. One way of arguing for more status for what nurses do is to argue for more status for women's work in general, because both are so closely linked in the public's mind. Work that women do outside the home is usually seen as an extension of their work as wives and mothers, and as they are "only doing what comes naturally" no great financial reward is justified. Nursing, with its strong connotations of nurturing and care, is the exemplary women's occupation, and so society's undervaluing of "domestic" work affects the status and material rewards of nurses, too.

Changing society's perception of women's work would change its perception of nurses' work, but the current chances of success are slim. There are easier ways of improving nurses' status.

STANDING ALONE

Another argument for granting more status to nurses follows from a rethinking of patients' needs. Both nurses and doctors have for a long time claimed to be concerned with the "whole person," and never more so than now. Regardless of the rhetoric, however, a doctor's gaze is still primarily fixed on the disease within the individual. (A glance at the list of contents of any recent medical textbook or journal confirms this.) Doctors, especially in hospital, see their main role as diagnosing and treating disease, and they

FIG 1—Stereotypes.

coordinate non-medical staff (of whom nurses comprise the largest group) to achieve this end. Within this scheme nurses are allotted the role of handmaiden, for which the ideal virtues are those that so ranked Florence Nightingale—devotion and obedience.

There are other ways of seeing a patient. Figure 2, which comes from a standard nursing textbook,³ shows the patient at the centre of a web of relations, and that with doctors is not pre-eminent. With nurses "the *only* health workers in close and continuous contact with patients"⁴ it has been argued that they, rather than doctors, may in some circumstances be the appropriate coordinators of health care. Doctors would be called in to help with specifically medical problems; in these cases the relation between nurses and doctors—"she helps him"—would be reversed to "he helps her."

This would obviously lead to a rapid improvement in nurses' status but a commensurate reduction in doctors' status, which explains, for example, doctors' reaction to "the nursing process,"⁵ seen as a step in that direction. Doctors' response to the Cumberlege report on neighbourhood nursing,⁷ which recommended the appointment of nurse practitioners, also showed that doctors strongly resist the idea of nurses acting autonomously. The government's policy of pushing health care back into the community (particularly for groups such as the elderly, the mentally ill,

and the physically and mentally handicapped) and its emphasis on preventing disease seem set to offer nurses more opportunities for autonomy—one of the key attributes of a profession.

FIG 2—Some members of the health care team who assist the patient and the family.³

PROJECT 2000⁸⁻¹⁰

The centrepiece of nursing's bid for professional status rests, as it has with most professional groups in the past, with education. Nurses want to replace the current apprenticeship training by an educational programme. Trainees would be accorded student status and would be supernumerary to the nursing establishment during their three year course, although about one fifth of their time would count as service contribution (the current proportion is about three times that). Service needs would no longer take precedence over educational needs, and at the end of their course nurses would have a qualification comparable with that provided by polytechnics and colleges of advanced education. Far from being unique, these changes would merely bring the United Kingdom into line with most other countries.

Some have doubted the motives of those who wish to improve nurses' training, as if everything were ticking over nicely now and should be allowed to continue undisrupted. This is not the case. The most recent poll of nurses' views found that 71% of final year students had considered leaving nursing in the preceding 12 months—that is, before they had even qualified.¹¹ (This was the largest proportion for any grade of nurse surveyed.) At present about 15 out of every 100 entrants to nursing either stop their training or pass their exams and fail to register.¹² The recent feasibility study into using trainees from the Youth Training Scheme in the NHS has recommended standards of training and supervision for potential nursing support workers that are higher than those for student nurses, which suggests if nothing else does that the training programme for nurses is in need of some sort of overhaul.¹³

Misconceptions about Project 2000 abound, both inside and outside nursing. One is that entry to the common foundation course will require higher educational standards than entry to registered general nursing courses does now. Another is that courses will turn out nurses with PhDs but few practical skills. In fact, minimum entry requirements will stay the same for the main route of entry, with additional routes of entry for those with vocational qualifications or from access courses. The United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, which is responsible for Project 2000, has emphasised that nursing will remain a practice based profession, with much of the training taking place in a practice setting. Although only one fifth of student nurses'

Project 2000—main proposals

A new division of labour

- A single level of *registered practitioner*, replacing both first and second level nurses.
- A more advanced grade of *specialist practitioner* (some of these posts will be disease linked, others will represent specialist knowledge in nursing intervention and health promotion)
- A support worker, the *helper*

A new pattern of preparation

- 18 Month common foundation programme followed by 18 month branch programme (in nursing of the adult, the child, the mentally handicapped, or the mentally ill)

Enhanced educational standard

- A qualification with a wider academic currency and of equal standard to other advanced educational qualifications
- Trainees given student status, and supernumerary to staffing establishment throughout their training
- Closer links with higher education sector
- Educational programmes beyond registration
- Qualifications at degree level for teachers

time will count towards service contribution, much more of it will actually be spent on the wards.¹⁴

What is interesting about the misconceptions about Project 2000 is that they all overestimate its academic standard and scientific content. Within nursing itself, ever since the "extended role of the nurse" was suggested, anxieties have existed that any move towards the right in figure 1 would necessarily entail leaving something behind, perhaps even the essence of nursing. These anxieties are most obvious in nurses' attitudes towards technology (box).

Career moves

ON THE WARDS

With our education you've got the capacity to go places, and yet if you're nursing you just don't go.

STAFF NURSE

All these girls have got at least two A levels, because you wouldn't get into a London teaching hospital without them. What the hell are they doing here wasting their time if they want a career that's going to last them the rest of their lives? If you're stupid enough to stick at it you can become a sister after three or four years of being a staff nurse. Then you've got increments of a few hundred a year that go on for six years and then what the hell do you do? Of the two senior nurses here, one of them spends all her time in the office filling in agency forms and working out when people are going on holidays. It's all desk work—it's something a reasonably competent secretary could do. It doesn't contribute anything to the nurses on the ward.

SISTER

To progress at all after six years you've got to become a nurse manager. I don't want to do that, to lose patient contact. The reason I'm in nursing is to look after people. Once you become a manager that's it, you don't go near a patient.

SISTER

Nursing sisters start their seventh year on a salary of £12 000, and if they remain in that post their salary will stay the same until they retire. To progress further up the nursing hierarchy (and salary scale) requires a switch from direct patient care to nurse management or nursing education. Very often financial reasons have dictated the decision "to advance." (To get some idea of the unhappiness this causes dedicated bedside nurses, compare it with

The technological fix

"The level of entry is far too high: you don't need three A levels to be a nurse. All this claptrap about technical equipment—any nurse can learn to do that. There's no need to glorify nursing's content. You're a carer, a compassionate carer: 80% of your day is spent in the care of patients, relieving pain, feeding, watering, and making the patients comfortable—practical skills."

SISTER

"With the technological development of medicine and so many things being given intravenously and because of the lack of improvement in the conditions of the medical staff—with housemen working 100 odd hours a week, which everybody recognises as being nonsensical and yet nothing seems to be done about it—nurses took on an extended role. It enabled medical staff to be elsewhere: rather than have a houseman getting up every hour during the night nurses are trained to take responsibility. Nurses now have many more responsibilities and if you're taking on added responsibilities then you're leaving something else behind. I feel that we have followed the medical model very closely in the development of nursing, sometimes to its detriment."

RCN AREA OFFICER

"There is this perception that basic nursing is about bedpans and complicated nursing is about defibrillating and dealing with all that machinery. There has been a strong tendency for nurses who want to improve their status to identify with the high tech tasks as the way forward and to dismiss the basic care and say I'm highly trained, I don't want to wipe bottoms any more. Instead they go for usually hands on medical tasks—tasks which doctors have got bored with and have looked around for someone who's cheaper to give the job to. Often nurses are only too pleased to take it on; they think doctors do this—it's a higher status task. I don't think minding machines is any more rewarding, or skilled, than wiping bottoms. Not if you see it in its whole context—is the person incontinent, if so why, what's the underlying problem, how will it affect their management?"

EX-STAFF NURSE

the medical career structure, where doctors are not driven from clinical practice in mid-career.)

Another complaint about clinical nursing is that further qualifications and training (for example, taking intensive care courses) are not rewarded, which removes incentives for nurses to improve their skills. This partly explains the current scarcity of specialty nurses.

(Recruitment by other countries and the independent sector, which pay more, exacerbates the problem.)

Help may at last be at hand for both these longstanding grievances. After a few years of prompting from the nurses' pay review body management and staff have agreed a new clinical grading structure, which will reward extra qualifications and clinical experience. If the new structure is accepted by the review body the government still has to agree to fund it, and there are encouraging signs that it will do so.¹⁵ At the time of writing, however, confusion still exists over whether the government will fund the new grading structure by reducing special duty payments for unsocial hours to a flat rate of £1.20 an hour. If incentives to work these periods are withdrawn undoubtedly many wards will have to close overnight and at weekends.

ABOVE THE WARDS^{18 19}

Nursing management has been in almost continuous flux since 1966: that year's Salmon report was followed by the reorganisation of the National Health Service in 1974, its restructuring in 1982, and the implementation of the recommendations made by Sir Roy Griffiths in his management inquiry of 1983.¹⁶ The results of such frequent changes have been widespread confusion, inefficiency, and demoralisation. According to one director of nurse education to whom I spoke, managers in her district have had to apply for their own jobs four times in the past 10 years.

The changes that occurred after the Griffiths inquiry are seen by nurses as the most damaging so far—for a time it seemed to them that their voice would be lost entirely, which is ironic given Sir Roy Griffiths's early assurance that: "The proposals don't threaten nurses at all. The nurses are doing a good job and the changes that are being talked about aren't designed to affect them, except beneficially."¹⁷

Before Griffiths the chief nursing officer was a member of the district management team, whose policies were decided by consensus, with each officer of the team having the power of veto (fig 3). The nursing officer had a guaranteed right to provide professional advice through a structure of nursing line management to the employing authority. After Griffiths the nursing officer was replaced by a district nursing adviser, responsible for giving advice to the newly created district general manager. The nursing adviser lost any guaranteed right to sit on the district management team, and according to the Royal College of Nursing about one third of districts lack an effective nursing voice. Units (the level below

FIG 3—Management: before and after Griffiths.

district) have directors of nursing services to whom nurses are professionally accountable but who are not responsible for controlling nursing policy, organisation, or budgets.

Further up the NHS hierarchy some regions lack effective nursing representation, and the apex of the post-Griffiths NHS, the health services supervisory board, omitted to include the chief nursing officer among its members for the first year of its existence. Regardless of the reasons for this, it was widely interpreted by nurses as a snub and symbolic of just how far their stock had fallen.

As a report on nursing after Griffiths states, "Nursing would seem to be the sort of topic that any rational health service general manager would wish to receive detailed advice upon—half the workforce and one third of the revenue budget cannot sensibly be ignored; in addition . . . nurses are in closer continuous contact with the clientele than any other part of the workforce."¹⁹

It is because nurses' salaries make up the largest part of the revenue budget that levels of nursing manpower have attracted the attention of general managers intent on making efficiency savings. Some of the ensuing cuts in staffing levels have been disastrous and would probably not have been made if there had been an adequate nursing contribution into making decisions.

Since its early nadir there has been a steady improvement in the representation of nurses at all levels. Nurses have also been appointed as general managers at regional level (1/14 posts), district level (5/192), and unit level (about 80/650).

Conclusion

Acceptance by the government of both Project 2000 and the clinical grading structure (without funding them by cuts in special duty payments) would go far to satisfy nurses' grievances about their lack of professional status and career. The government's

decision should be known in the next few months. A question remains, however: why do nurses now regard the lack of both of these so crucially important? This cannot be satisfactorily answered from within nursing. In my next article I will look at how wider social forces impinge on nursing and examine in more detail a theme touched on in the first four articles of this series: the consequences of seeing nursing as women's work.

References

- 1 Woodham-Smith C. *Florence Nightingale 1820-1910*. London: Constable, 1950:340.
- 2 Abel-Smith B. *A history of the nursing profession*. London: Heinemann, 1960.
- 3 Roper N, Logan WW, Tierney AJ. *The elements of nursing*. 2nd ed. Edinburgh: Churchill Livingstone, 1985:12.
- 4 Rowden R. Doctors can work with the nursing process: a reply to Professor Mitchell. *Br Med J* 1984;288:219-21.
- 5 Mitchell JRA. Is nursing any business of doctors? A simple guide to the "nursing process." *Br Med J* 1984;288:216-9.
- 6 Currie CT. The nursing process: revolutionary philosophy or passing phase? *Br Med J* 1984;289:1218-9.
- 7 Community Nursing Review. *Neighbourhood nursing—a focus for care*. London: HMSO, 1986. (Cumberlege report.)
- 8 United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. *Project 2000: a new preparation for practice*. London: UKCC, 1986.
- 9 United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. *The common foundation programme*. London: UKCC, 1987. (Topic paper 4.)
- 10 United Kingdom Central Council for Nursing, Midwifery, and Health Visiting. *Widening the entry gate*. London: UKCC, 1987. (Topic paper 5.)
- 11 Casey N. What's wrong with nursing? (Harris poll). *Nursing Standard* 1987 October 3:10-1.
- 12 Price Waterhouse. *Report on the costs, benefits, and manpower implications of Project 2000*. London: UKCC, 1987:2-13.
- 13 Price Waterhouse. *Feasibility study into YTS in health and social care programmes*. London: DHSS, 1987.
- 14 Anonymous. News on Project 2000. *Br Med J* 1987;295:1421.
- 15 Thatcher M. Parliamentary oral answer. *House of Commons Official Report (Hansard)* 1987 Nov 24;123:col 137 (No 50).
- 16 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
- 17 O'Brien RB. Nurses have "potential for top NHS jobs." *Daily Telegraph* 1983 Nov 18:11 (cols 4-6).
- 18 National Association of Health Authorities. *NHS handbook*. 3rd ed. London: Macmillan, 1987.
- 19 Robinson J, Strong P. *Professional nursing advice after Griffiths—an interim report*. Coventry: Nursing Policy Studies Centre, 1987. (Nursing Policy Studies 1.)

Personal Paper

What should psychiatrists be doing in the 1990s?

GLIN BENNET

Large numbers of mental health professionals are now working in the community and in mental hospitals. They come from various disciplines and use a variety of explanatory models. Where do psychiatrists fit in this new pattern and what will be their role in the future? Thus established psychiatrists want to know how they are going to fit in with the developing community services, and psychiatric trainees want to know how best to prepare themselves for a new and so far undefined role.

Psychiatrists are having to respond to changes in society, to the expectations of the consumers of health care, and to the contributions and philosophy of the varied health professionals currently at work in the community.

Until recently the psychiatrist was the sole responsible professional dealing with mental health problems. Of course, there were skilled mental welfare officers, social workers, child care

officers, and others, but the psychiatrist was the only one publicly accepted as an expert, and was the one who held the key to admission to mental hospitals, which was usually seen as the only option for people with pressing psychological problems.

Now things are different: new kinds of professionals are established on the mental health scene—for example, clinical psychologists and community psychiatric nurses—and some of the existing ones have augmented their skills and broadened their vision—for example, general practitioners, health visitors, and social workers.

There is an ideological change, too, which I suspect will prove to be more important in the long run than changes in management structure and clinical practice. The health professionals do not have a medical training, and so tend not to conceive the problems of living in terms of illness. These professional people are primarily interested in health, and variations on ordinary functioning are seen as far as possible in social terms; doctors, by contrast, are primarily interested in illness and so are apt to view such variations in medical terms. That is not to say that health professionals are incapable of recognising physical illness or major psychiatric disorder—far from