Has nursing lost its way?

Dual perspective

Jacqueline A Short

A doctor and three members of the nursing profession give their views on the changing role of nursing in Britain.

It was with a mixture of pride and trepidation that I rounded the final bend and drove up to the same psychiatric hospital that had seen my arrival as a student nurse 17 years previously. I was back again, but this time as a senior registrar in psychiatry. Would anyone recognise me? Would my nursing colleagues welcome me or treat me with suspicion for defecting to the other side? The moment of truth was looming.

Nursing roots

At the age of 18 I surprised myself and disappointed my school by deciding to train as a nurse. What a waste of a grammar school education! In a misguided attempt to combine my chosen career with travelling the world, I joined the Queen Alexandra's Royal Naval Nursing Service. The defence cuts had started. By the time I had become a state registered nurse three years later, I had seen Portsmouth, Plymouth, and Southampton. It was while on secondment with the army at the Royal Victoria Hospital, Netley, however, that my initiation into psychiatry started. That initiation became a baptism of fire when I began further training to become a registered mental nurse, but this time, as a civilian in an NHS psychiatric hospital.

As I drove slowly through the grounds again, memories came flooding back. I cringed at my own ignorance. The ward sister's words still ring in my ears at my attempts to safely contain and distract my first manic patient by joining in with the infectious laughing and dancing. But for my crisp uniform and white cap, sister would have thought there were two manic patients on her ward.

Red "suicide caution cards" were received and signed by the "specialling" nurse with as much enthusiasm as if she was receiving the black spot. There was no diffuse team responsibility here. For however long the sister or charge nurse decreed, a nurse would be responsible for ensuring the whereabouts and safety of the patient deemed at risk of suicide. It was mentally and physically exhausting. We looked wistfully at the doctors who swept into the ward for their comparatively brief encounters and then left for their academic meetings.

It was not until I became a ward sister that I felt that consultants could be addressed with any form of clinical equality. They could often be encouraged or cajoled to include nurses when teaching junior doctors on ward rounds. Such teaching fostered my own academic interest in a subject that was so intrinsically fascinating but of which my knowledge only extended to the skills demanded by my own profession. I threw myself vigorously into nurse education, reading around my subject and wanting to know more and share more with each group of nursing students assigned. It was as a registered nurse tutor that I finally decided to take the plunge, and as a mature student who felt like Methuselah I entered medical school. I emerged several years later with a large overdraft and a resolve to become a psychiatrist.

I resisted the lure of returning to my old, familiar

hospital to undertake my postgraduate training; it seemed almost incestuous. Instead, I spent four years training and working in a completely different mental health service, which broadened my experience and offered alternative models of care. Now, as a senior registrar, I feel that there has been a decent enough period of absence for me to return to continue my higher professional training.

Evolution or revolution?

Six months have passed since I arrived at my old psychiatric hospital. What has changed? Was I right to be worried? The first few weeks were whirlwinds of hugs and recognition. Most of us had gained some grey hairs and wrinkles. Tales were exchanged and then we each surveyed the other in our new roles. My nursing colleagues have evolved into managers and skilled therapists, and the talk is of "clients" and "empowering."

I feel like a dinosaur as I slowly realise that psychiatric nursing is not the profession I recall. Caring junior nursing colleagues have adopted the role of "clients' advocate," and the teaching is centred on psychosocial concepts of mental health. Mental illness seems to be a perjorative term and its very existence questioned. Of course, there is an important psychosocial component in the presentation of mental illness, but it is clearly not the whole story. Mental illness undeniably affects a patient's physical and mental state, and too rigid an adherence to the principle of patient autonomy can have serious, and sometimes life threatening, consequences. For example, it is a fine dividing line between encouraging disturbed "clients" to accept drugs that they do not feel they require or to adopt a more healthy sleep routine, and being patronisingly coercive. Recognition of that line, however, has always been one of the skills unique to the psychiatric nurse. Working alongside patients and helping them with their activities of daily living seems to have become the province of the health care assistant.

"In striving to become a respected profession, psychiatric nursing is losing that unique body of knowledge and skills that defines it as a profession."

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Nurses may lose their role of helping patients with activities of daily living

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private tasks helps to build the therapeutic relationship on which assessments of mental state are accurately based.

Clinical teaching placements can no longer offer these practical skills, as the senior nursing colleagues from whom nurses previously learnt so much have been caught up in the tide of health service reforms and in many cases no longer have any contact with patients with acute conditions. With the move to community care, others are now working as primary therapists in the community. The role models of the specialist skills needed for acute, inpatient care have gone. The nursing profession in general has never properly recognised, or rewarded, those clinical nurses who chose to stay at "ward level." They are regarded either as lacking in direction and initiative or as being too rigid and unable to adapt to the new progressive thinking. Perhaps that explains my defection.

At least as a doctor I am able to maintain my contact with patients, and perhaps also take up the role of advocate, by encouraging junior nursing colleagues to see patients in a more holistic light and not to dismiss the medical model. We must address this imbalance. The right of our patients to have the best multi-disciplinary care depends on it.

Nursing and medicine: cooperation or conflict?

Ann Bradshaw

Two years ago a newspaper's foreign correspondent in Russia described her observations of health care in post-communist Moscow. Through her visits to a sick friend in hospital and conversations with her taxi driver, whose mother was in hospital, the correspondent came to see a system of health care based on contractual, material rewards: flowers, chocolates, and perfume for the nurses; crates of whisky for the doctors. Sitting on her friend's bed (for which the patient had to provide her own linen and pillows), the correspondent watched in horror as nurses provided the expected "tender loving care" to some patients—changing bedclothes, taking temperatures, and giving tea—but ignored other patients completely, even if their sheets were horribly soiled and they were crying out for a glass of water. These patients, or their relatives, had failed to give the nurses any presents:

no presents, no nursing. The correspondent concluded that we should be thankful for our own NHS.¹

But I wonder if the correspondent's horror at the cold hearted contractual nursing she witnessed was the result of her own assumed and inherited expectations that nurses are inducted into a tradition of "tender loving care"? Does she still taste the fruit of a tree which is now almost cut down? British nursing, under the powerful influence of North American sociological, psychological, and educational nursing theory, has undergone a rapid transformation since the 1970s, which makes such assumptions questionable. Indeed the past 20 years have seen a revision of nursing history and a rejection of the traditional nursing ethos. Contemporary British nursing theorists have vigorously sought to challenge both the "biomedical" view of care and the moral values that underpinned it and, most particularly, the concept of nursing as altruistic, self effacing service—dare I say, vocation. The new nursing values of autonomy and empowerment, rejecting what is mistakenly and simplistically perceived to be the past nursing values of submission and obedience, have deconstructed the sense of continuity with the past and led to a loss of authority in the present.²⁻⁴

The break with tradition

These axioms have led to a new orthodoxy, which has brought fragmentation to the nursing profession as each nurse is taught to become a wholly autonomous practitioner; hence, the ward sister no longer inducts her charges into a tradition but rather takes on the role of a detached business manager. It has also brought alienation of the nursing profession from the medical profession because doctors, particularly male doctors, are seen as the perpetrators of past nursing oppression still intent on holding nurses in subservience. No doubt both ward sisters and doctors bear some responsibility for this sense of alienation, perhaps by exercising authority in the form of power rather than as authority vested in a shared moral tradition of fairness, justice, and care. But this overreaction has resulted in an often implicit sense of rejection of doctors as unfeeling technologists and, sadly, in a sundering of the science and art of care. At the same time the concept of care is now very problematic for nursing theorists, and the loss of continuity with the past means that the notion of care has become the subject of academic inquiry and empirical research, predominantly derived from the social sciences. Indeed, as the consultant orthopaedic surgeon Robert Hay has recently noted with sadness, the value of bedside nursing care is devalued in favour of what he believes is the pursuit of a "pseudo-intellectualisation" and an attendant "pseudo-managerial gibberish."⁵

Fragmenting moral values

Nursing, however, is not independent of the mores of society. Does the change in the identity of nursing merely reflect the moral state of society and health care within it? Alasdair MacIntyre's *After Virtue* offers us an illuminating template.⁶ Drawing on Max Weber's thesis of bureaucratisation and rationalisation, MacIntyre argues that the destruction of the inherited moral tradition has resulted in an emotivist culture dominated by three types of attitude exemplified in the characters of the aesthete, the therapist, and the manager. Their emotivist concerns are no longer those of the truth discernible through moral debate; rather they are the values of efficiency and measurable effectiveness derived from the imputed skill and knowledge of the so called "expert." Values are utilitarian; ends are given and are outside the scope of