

## EDUCATING NURSES TO PROTECT THE PAST OR TO ADVANCE HEALTH CARE?: A POLEMIC

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### ABSTRACT

**Internationally nursing is challenged by recruitment and retention issues. On the one hand nursing is expanding and extending practice whilst on the other, lesser skilled workers are undertaking many roles which were previously fulfilled by nurses. This opinion paper contextualises the current debate and outlines many of the reasons that have been proffered for the apparent shortage. It then progresses to suggest strategies that may ensure nursing remains relevant to contemporary health care. Essentially a presentation of the author's views, the intent of the paper is to generate debate.**

### INTRODUCTION

**T**his paper presents a discursive analysis of the state of nursing within the Australian health system, drawing on our experience in nursing practice, nursing education, nursing management and nursing research. As such, then, we do not draw on an extensive literature; rather, we offer up a critique and posit some suggestions on why things are as they are, and how nursing could respond to the current demands for health care.

The emergence of modern nursing and the resulting recognition of the importance of high quality nursing in the nineteenth century immediately created an ongoing cycle of over- then under-supply of nurses (Pearson, Taylor and Coleborne 1997 p.1). Most Westernised countries have a long history of commissioning and implementing strategies to meet the needs of the community for access to nursing; and all have, eventually, been found to be ineffective.

Until the 1930s, the lack of professional opportunities for young women created a ready supply of 'probationer' or 'student' nurses. These poorly paid workers carried out most of the nursing work in hospitals and nursing homes under the supervision of a very small qualified workforce. The few who 'stuck at it' and eventually qualified often struggled to find employment as registered nurses as few positions existed, given that the nurses in training did most of the work; and at a very cheap price. This situation changed rapidly with the advent of the Second World War and the broadening of work options for women that flowed from it. Most countries responded by creating a second tier of nursing training (the assistant nurse, the enrolled nurse or the nurses' aide.) Many leaders envisioned a large workforce of 'pupil nurses' or trainee nurses aides; a smaller workforce of student nurses; an even smaller group of second level nurses; and a leadership group of professional or registered nurses. In some countries, a third level of nursing worker - the auxiliary or nurse assistant - was introduced to supplement the growing legion of various levels of nurses.

Constant variations of this complex jigsaw have come and gone in the past 50 years. The profession's vision of an all registered nurse workforce, educated to degree level in universities, and the demise of the second level nurse seemed more possible in the latter decades of the twentieth century (Pearson 1992, p.16-17). But, as the 21st century begins yet another workforce shortage looms and the debate on who should be nurses; how nurses should be educated; and what constitutes the legitimate role of various levels of nurses still rages despite 150 years of trying to evade a problem that is unlikely to go away.

Given the rapid development of nursing in Australia over the past 20 years and our responsibility as professionals to develop strategies to ensure that high quality nursing is accessible to all Australians, we wish to argue that it is time the occupation of nursing re-focused on rationally re-constructing the composition of nursing service. Such a re-construction needs to address society's continuing need for nursing and to accommodate those with a desire to care and the ability to do so. If nursing is about assisting people and communities to meet their goals that otherwise may be thwarted because of illness or disability we need to be aware of and responsive to what is happening in terms of health care and health challenges and to prepare nursing workers to practice within complex, changing health systems. It is becoming increasingly clear that the 'dreamed for' all-RN nursing service is unrealistic. This is partly because nursing, as a labour intensive activity, requires large numbers of people and there will never be sufficient RNs to meet the needs of communities for the provision of nursing care. Economically, highly educated professional nurses demand and, as it should be, receive significant remuneration. Given the contemporary funding crisis in health care, even if we were able to supply sufficient RNs to provide nursing care, funding levels are such that it would be impossible to fund.

This paper is based on the assumption, therefore, that if nursing education is to fulfill its obligations to advance health care and remain relevant it must be responsive to changing health care needs in the broader society. Before examining education for nurses it is useful to briefly explore the context of health care and nursing.

### **The context of care**

It is not intended here to undertake a comprehensive review of the context of health care, rather to highlight that there are changes impacting on educational needs and to provide some significant examples. These include: the ageing population, the increase in chronic illness/disease and especially mental ill health, emphasis on self care, increased provision of care in the community and greater demand for complementary - non Western/biomedical approaches to health care. The broad expectation that individuals and communities have a right to good health and the technological explosion have resulted in increasing expense which is leading governments to look

for more economical ways of offering care. The requirement for individuals to fund their own care and the emphasis on self care and consumer rights is associated with more litigation (Nay et al 2000).

These changes increase client need for assistance to co-ordinate care delivery and information to facilitate access, informed decision making and self-care. Nurses can play a major role in negotiating appropriate care, influencing health care policy, lobbying to improve access and continuing to provide direct and indirect client care. A national morbidity study in the United Kingdom 'found that 30% of GP consultations are 'trivial' and do not need the assistance of a doctor' (Dargie 1999). Research projects on the nurse practitioner role in Australia and advanced roles internationally indicate that nursing can provide a significant amount of generic health care more cost effectively than general practitioners and without loss of quality (Buppert and Knight 1995; Doult and Watson 1998; NSW Department of Health 1996).

At the same time as there are increasing demands for the type of care nursing is well suited to provide - young people are no longer choosing nursing in the large numbers which in the past could be expected and many student/graduate nurses are choosing to work only casual/part-time in nursing or are leaving nursing altogether (Australian Institute of Health and Welfare 1999). Terms such as 'critical nursing shortage' and 'crisis' are becoming commonplace and government concern has resulted in various studies and a national forum in September 1999.

### **Where are the nurses?**

There appear to be a number of reasons, which together may help explain the current perceived shortage. These include (Nay and Closs in press 2001; Reid 1994; Nurses Registration Board NSW; Ogle and Ferguson 1996; Warr et al 1998):

- the employment opportunities for women have greatly expanded beyond the traditional occupations of teaching, nursing and domestic work;
- many nurses are choosing to work only casually or part time;
- it is still the case that women are more likely to be the main child carers;
- many just want a 'job' - they are not interested in a professional career and all that that requires - their preference is for 'blue collar' conditions in terms of working shifts and not having to do more 'in their own time';
- despite the movement of women into traditionally male employment areas little effort has been expended to attract men to traditionally female occupations and men in general are not attracted to nursing;

- in the workplace criticisms of hierarchical management structures, horizontal violence and victim behaviours remain common and many contemporary nurses will not tolerate such work pressures;
- remuneration does not encourage nor reward self-funded education - in dollar or time terms;
- excellence is not sufficiently rewarded - 'a nurse is a nurse is a nurse' in many instances; 'tall poppies' are still frequently discouraged and there remains a view that academic and practical skills are mutually exclusive;
- many students still complain that they face punitive, maternalistic situations in which a form of obedience is still required and debate and rigorous questioning are still discouraged - men in particular have complained about the treatment they receive;
- the collegiality between industry and the academy has much room for improvement;
- the image and status of nursing remains poor;
- nursing is perceived to be for the 'not so bright' and bright students are counselled away from choosing nursing;
- the relatively low university ENTER scores reinforce this view;
- the three year undergraduate preparation has long been seen by nursing leaders as insufficient; the sheer body of knowledge and skills that nurses require to be safe comprehensive practitioners can not be taught adequately in six, 13 week semesters - most, if not all, other health professional preparation in Australia provides at least four years of learning time;
- criticisms of inadequate clinical preparation and insufficient preparation in areas such as aged care, mental health and palliation are also common;
- perhaps as a result of the low ENTER score, many nursing students have great difficulty with the sciences and most universities now have special science subjects for nurses (often referred to as 'veggie science') - whereas other allied health and medical students are able to study the same (rigorous) science - this simply confirms the view that nurses are not equal to their professional colleagues from other disciplines;
- student/graduate nurses (not surprisingly, given these factors) often feel of lesser ability than the other health professionals, lack confidence and frequently 'do not have a voice' - all of which in turn can explain continuing horizontal violence and workplace problems not conducive to attracting and maintaining career minded staff;
- the lack of clear articulation between EN and RN and insufficient RPL leads to nurses wasting time and

money on education they do not need and possibly giving up before gaining the more appropriate education; and finally

- it has been argued that many 'nursing' positions are now being lost to other workers.

### The way forward?

We could respond to this situation by continuing to argue for increasing numbers of RNs and ENs; we could fight the encroachment of generic workers onto our patch; we could continue to demand unrealistic educational overlap 'to maintain standards' rather than sit down and work out a clear articulation that recognises prior and current learning and so on but we would argue that this is not the way to advance health care or nursing and in fact could see nurses made redundant. While we try to maintain the current RN numbers we will increasingly face 'shortages' and continue to have problems with workplace organisation/management and unhappy work-lives for nurses, however styled.

For a very long time leaders in Australian nursing had argued that there must be only one level of nurse, that all nursing care should be delivered by RNs. There was a hope that if we refused to educate PCAs they would 'go away' and to agree to educate them was hypocrisy and exploitation of them and the people who had to receive their care. In other words - if these people needed education in order to do the work they were doing did not that demonstrate that an educated person - i.e. a RN - was required? However, for the past thirty years at least we have had unlicensed, 'unqualified' people making up a large proportion of the aged care workforce.

It has also been common to see nurses - enrolled and registered wanting to move away from the bedside and direct care. Promotion for being 'good' at nursing has been to move away from the bedside into administration or education.

Despite the efforts of many nurses, the numbers of unlicensed workers in aged care is rising, not dropping AND they are moving into other areas of health care. This is occurring in an unplanned way to fill 'nursing' vacancies because nurses are variously: not available, too inflexible, too expensive and/or not seen to be adding value.

So what do we see as a more useful approach - yes probably pragmatic - but also we would argue more likely to result in quality outcomes for clients? We want to paint something of a futuristic scenario (a) because it is the best approach we have been able to conceptualise thus far and (b) to encourage debate, discussion and better ideas from those who disagree. It is essential that nurses do not simply criticise and obstruct change - if the ideas presented are not considered acceptable then for nursing to progress those people who disagree are responsible for providing something more appropriate - we invite such debate.

## A possible future

- 1 Nursing has a broad vision - it is no longer considered good enough to just put a 'band-aid' here or there and hope we can go back to 'the good old days'. The recent National Forum - Rethinking Nursing (Department of Health and Aged Care 1999) proposed a national workforce committee, a national chief nurse and a national strategy. Nurses united can lobby governments at all levels to bring these ideas to fruition.
- 2 We look again at the nature of nursing and who should perform it - certainly nurses need to develop nursing knowledge and skills - but they will never - have never - **provided** all nursing. Nursing/nurses could concentrate on developing the discipline, gathering the evidence and testing it in practice; informing health care; assessing who should provide care and at what level; monitoring that appropriate care is provided teaching appropriate care and providing care where the context requires it. Nursing is not just a set of tasks - if someone other than a nurse gives out the medications nursing will NOT collapse. However, if we concentrate on just keeping tasks it might!
- 3 Most nursing care has been and still is provided by families, non-nurses and vocational nurses - there are in fact relatively few genuinely professional nurses. If we accept this rather than pretend it is not the case we can then plan proactively rather than simply react to 'shortages'.
- 4 A more proactive way forward could be to develop a system - not unlike the current one in terms of types of people delivering care but one that is more rationally recognised, planned and utilised with a genuine focus on client/community outcomes.
- 5 This system would draw upon workers of various distinctions to make up an appropriate team - it could have family members, Health Care Assistants (HCAs),<sup>1</sup> Licensed Practical Nurses (LPNs)<sup>2</sup> and RNs delivering nursing. The educational preparation would reflect the level of competencies required for each staff level.
- 6 In this model HCAs could have fairly basic preparation - from six to 12 months - they could provide care to people who were assessed by the RN as being quite stable and probably cognitively intact. LPNs would have a broader scope of practice than they currently enjoy and would require a stronger educational base - say two years. They would make up the vocational proportion of the workforce - the educational preparation, and rewards would reflect the vocational nature of the role and associated expectations. RNs would be a relatively smaller proportion of the workforce - they would have greater expectations placed on them and would be rewarded accordingly as professionals.
- 7 RNs would be genuinely professional and adopt a life long approach to learning - and their professional remuneration along with the multiple modes of delivery available would assist them in accessing the education. Credentialling would be the norm.
- 8 Undergraduate education for RNs would involve four years of preparation - this would allow time for increased emphasis on those areas currently criticised: clinical, mental health, ageing, leadership, research, negotiation skills, rigorous science and so on. The smaller numbers would facilitate a rise in the ENTER score and thus impact positively on image; undertaking the sciences together with other health professionals would improve the sense of collegiality and confidence. Professional expectations would mean that this group would take responsibility for leading the profession; ensuring care is evidence based; lobbying for adequate resources; providing public comment where relevant, deciding what an appropriate skills mix might be in any context; modeling and monitoring best practice; critiquing and researching practice, etc.
- 9 There would be very clear educational articulation from the generic health care worker preparation through the practical nurse and the professional nurse. Recognition of learning would facilitate rather than obstruct multiple exits and entry points. Students would be able to take out the vocational license while undertaking the four-year professional practice degree. Universities and TAFE colleges would work more cooperatively to ensure the best outcome for students and clients.
- 10 Education would be more closely linked with practice environments. We would move to much closer partnerships - knowing now the principles we wish to sustain while having the confidence to embed learning back in practice. For example, students could be linked with a major health care provider and undertake the majority of their clinical experience with that provider. The provider could agree to provide paid work and reduce the need for students to work in situations that do not maximise learning opportunities. Objectives could be established that recognise learning does occur outside semester and thus some recognition of current learning may be possible. The student's greater familiarity with the work environment would reduce the sense of 'burden' felt by the staff. Students would graduate feeling really familiar with the real world - they would be welcomed by their colleagues who have been closely involved in the education and growth and know they are useful colleagues. They would also be already used to feeling a valued part of the multidisciplinary team. The organisation would have adopted a learning organisation philosophy and would encourage debate and questioning as the essence of best practice. Clinical supervision/preceptorship would be

provided by the industry partner staff (who would be university title holders) not sessional teachers who are often seen to be 'visitors' to the organisation.

- 11 There would be many more combined degrees which would provide nurses with the flexibility to work across health care situations - these would be consistent with multipurpose centres, integrated care models and nurse practitioner case loads.
- 12 The more planned and appropriate skills mix with knowledge/qualifications better matching care delivery requirements would increase confidence and reduce horizontal violence. Thus the workplace would be a more attractive place and recruitment and retention problems would be minimised.
- 13 Universities would have been forced to further rationalise and there would be a greater emphasis on quality rather than quantity. This smaller number of nursing faculties would have produced stronger teams of experts who are not spread so thinly they can not maintain quality in teaching and research while also maintaining their own clinical credibility. Industry partnerships would also be stronger and RPL the norm at PG level. The many streams we currently offer would have been better considered to determine what should be 'learned on the job' and what higher level knowledge development universities should take responsibility for.
- 14 In this environment nursing would be equally attractive to women and men - and nurses would no longer eat their young
- 15 Experienced nurses in all spheres of practice, education, administration, credentialling, etc would recognise the need to model best practice.

## CONCLUSION

The context in which nursing is practised has changed enormously. As a result there are increasing demands for care which potentially nursing could meet. However, recruitment and retention of nurses is problematic and the consequences could leave the profession of nursing

marginalised and/or redundant to health care if we do not recognise and involve ourselves constructively in the changes. We have argued that nursing must change and suggested ways in which this might be progressed. Central to our argument is the belief that a healthy future for nursing requires nurses to forego old territorial battles and instead allow the health needs of consumers and societies to direct the developments of the profession.

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## FOOTNOTES

- 1 The term HCA is used loosely here to refer to generic unlicensed assistive personnel.
- 2 The term LPN is used here to refer to a second level nurse, more highly educated than current enrolled nurses.