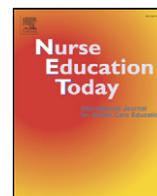


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Nursing's crisis of care: What part does nursing education own?

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Unless the 'Crisis, what crisis?' dictum guides you, you cannot be oblivious to the seemingly endemic erosion of caring and compassion in Nursing. This crisis has been long fermenting but came to a head with the UK revelations in the initial 2010 Francis Report and in the Patients Association landmark report of 2009. The latter did not soften its blows by absolving individual nurses and conveniently blaming 'the system'. Part of the problem was some nurses who couldn't care less.

These reports were firestarters. Naively, we may have expected the public to rally behind their beloved nurses. Quite the contrary. It was now open season and former patients and families took to the press and internet in droves detailing their own nursing horror stories. This genie was now well and truly out of its bottle. Nursing's spokespeople defended nursing by stressing that these horrors were emphatically not the norm and that great nursing care still existed. All well and good, but this is not an existential card game with people's lives. Great nursing care should not be a crapshoot or a lottery. Mrs Smith in room 1 receiving exemplary care does not cancel out Mr Smith in room 2 being almost systematically neglected. A 'royal flush of transformative nursing care narratives' does not beat a 'pair of nursing horror stories'. Nursing's other self-preservation move has been trying to write this crisis off as a media beat-up. This simply won't wash. Consistent reports of poor care are not 'bad publicity', they are bad care and grasping that distinction is as vital for nursing education as it is for clinical practice.

No nurse should be complacent enough to believe that this is an exclusively UK or 'NHS' problem (Wolf, 2012). In Australia and New Zealand for example, nurses will (at least privately) readily admit to the existence of similar shortcomings in care and to working with nurses bristling with 'bad attitude', while being grateful that this issue does not fill the pages of their newspapers. Not yet.

There have been copious suggestions regarding how clinical and health services are expected to change to confront this crisis. From the Patients Association's Care Campaign, through the UK Chief Nurse's '6Cs' initiative, to journalist Christina Patterson's '10 point plan for Nursing' (Patterson, 2012). It seems that hospitals and health services must change their culture and practices almost root and branch "to ensure that incidents like these never happen again blah, blah, blah...". Apart from some simplistic sloganeering about getting nursing out of the universities and back into the hospitals

however, there have been few similar calls for action directed towards nursing education. The question for nursing education is: What part of the crisis in nursing care do we own?

What Part of the Crisis Does Nursing Education Own?

What are nursing education's responsibilities related to both the devaluation of fundamental nurse caring and for restoring public confidence in nursing as an elementally caring service? If we believe the UK Council of Deans of Health (2012), then the answer is 'very little'. Their response to the UK Chief Nurse's '6Cs manifesto' is a masterpiece of self congratulation about how 'we are already doing this' combined with the usual rent seeking suggestions about needing greater 'investment' that will doubtlessly allow nursing education to do more of the same for longer. Add to this the recent 'phrase that pays' from nursing education's own echo chamber, the Willis Commission Report that, "The commission did not find any major shortcomings in nursing education that could be held directly responsible for poor practice or the perceived decline in standards of care." (Willis, 2012, p. 6) and it seems that nursing education is off the hook.

We are not so sure nor so reassured. Nursing education needs to do its own critical thinking that we so value in our students. Similar red flag concerns about nursing education are invariably raised by nurses, whether they be in Australasia, North America or Europe. These should not be new to anyone in nursing education, so what do we intend to do about them?

Let's take primarily the abandonment of 'basic nursing care' to a growing army of unqualified and largely unregulated care assistants. A hospital CEO in Australia has recently suggested that training nurses to undertake e.g., colonoscopies, endoscopies, cystoscopies and X-rays "was an innovative way of stretching them to their full potential while sparing them more basic tasks (our emphasis) such as washing and feeding patients – jobs he said less skilled and lower paid nursing assistants could do" (Medew, 2013). What role has nurse education played in devaluing and marginalising such care? What have we done or failed to do in our curricula, in our teaching or in our relationships with 'service partners' that contributed to the situation where such essential nursing care is being seen, even by default, as being the realm of the HCA (health care assistant)?

The Willis Report stopped stroking nurse education long enough to note that: "The commission finds it unacceptable that staff whose competence is not regulated or monitored are caring for vulnerable citizens (...) It is equally unacceptable that registered nurses must take responsibility for supervising colleagues on whose competency they cannot rely." (Willis, 2012, p. 28). This is painful to read, especially when accompanied by the even more excruciating question that should be

rhetorical, but isn't, "The question of core purpose was also posed: was nursing education preparing nurses to manage care delivered by others, or to nurse patients themselves, or a combination of both?" (Willis, 2012, p. 24).

We are now entering Nursing's 'Heart of Darkness' and this is Kurtzian Horror. When health services and clinicians complain of students or graduates lacking a clear sense of nursing purpose (we almost said 'vocation') or struggling to find a coherent professional nursing identity, or being ambivalent towards the importance of fundamental nurse caring and their role in providing this, we know they are not imagining this. By this same token, it is not hard to see how fundamental nursing care can become an option that nurses can choose to engage with to whatever degree, or not. Perhaps their 'core purpose' is simply to 'manage care delivered by others' – others who, paradoxically, may have more skill and experience in providing this 'basic care'.

As Hasson et al. (2012) ask so pointedly in a new study showing how HCAs in the UK now "play a major part in the education of student nurses with regard to basic, clinical, and non-clinical tasks", (p.1), "If one accepts that HCAs are delivering the majority of patient care, (our emphasis) should they be teaching such skills and not the RN?" (Hasson et al., 2012, p. 8). Logically, why not? Have we 'progressed' from the much maligned "see one, do one teach one" approach of yesteryear to today's 'austerity measures special': "Hear about one, simulate one, supervise all the others"?

How has nursing education contributed to this malaise? What happens or doesn't happen in a school's "education process" that would "reduce students' caring behaviours" (Murphy et al., 2009, p 254)? Does your school have explicit and hidden curricula and an ethos where nurse caring, kindness, compassion and 'basic care' are little more than ghosts in the machine? These are the culpable curricula wherein "basic/fundamental nursing care" is the practice that dare not speak its name, occluded by acres of well meaning, faculty-friendly filler about 'autonomy', 'ethics', 'health promotion', 'empowerment', 'equity', 'reflection', 'issues', 'leadership', 'wellness' and their ilk. In such curricula, fundamental nursing care and caring, are, we are told, 'implicit', 'integrated', 'blended' or 'thematized', in other words, largely invisible, languishing at the bottom of any "hierarchy of care skills" (Thomas et al., 2011, p. 662).

That we can even have such a discussion about the place of caring and kindness in nursing education and whether 'nursing patients' is a 'core purpose' of nurses is beyond embarrassing. It is a professional affront. If nursing education cannot provide a clear answer to the question, 'What are nurses for?' that includes, in large flashing lights: 'caring for patients and people', then we deserve all the opprobrium coming our way. Worse, we will surely need to move aside for the next manifestation of nursing education that does not see caring, compassion, kindness, service and the ability to 'assist the individual, sick or well' (you know the rest) as a professional or intellectual insult.

If you think this is 'scaremongering' think again. As one example, a social enterprise company in Canada, 'Nurse Next Door' (www.nursenextdoor.com) was created following their founding partners' underwhelming experiences of 'standard home care services' for their loved ones. Thinking, 'this shouldn't have to be this way' and embodying the clear idea that: "It's about caring, not just health care™" as a unique selling point, what differentiates them from other home nursing services, is Caring. It is hardwired into their values, operations, hiring and firing and everything they do. Without that caring ethos, their service has no meaning. Nurse Next Door is a successful business using Caring as its unique foundation. The 'gap in the market', that they fill is, incredibly, the 'Caring' we used to believe was inalienable within Nursing. How long before other social entrepreneurs look to hospitals and mainstream health services and realise that they could offer and organise such services significantly better? Not too long, some would say.

Intelligent or Caring?

We absolutely need intelligent, smart, thoughtful, hard-working, enterprising, creative and questioning students and nurses who have a verve for becoming more enthusiastic, more knowledgeable and even more humbled by just how much about the world, nursing and the human condition they don't know. This is never a battle between 'intelligence' and 'caring'. The public is adamant that they want nurses who are the complete package. Numerous studies have shown that people want skilled, competent nurses who confidently manage and help them manage the technical, procedural and treatment elements of their condition and care. They want nurses who listen, understand and communicate with them as fellow human beings. They want nurses who are 'in their corner' and who 'have their back', to help them navigate often alien and impersonal health systems. Above all, they want nurses who do all of this while bringing care, kindness, compassion and thoughtfulness to their everyday health encounters. Is this a 'big ask?' Damn right it is. This is why great nursing is not easy and why not everyone who might want to do it can or should do it.

In a recent study, Griffiths et al (2012) rediscovered and reaffirmed this:

"Service users and carers reported that nurses need to be technically competent and knowledgeable, and able to find information or to seek help when they lack knowledge or skills. However they unequivocally prioritised 'softer' nursing qualities, attitudes and skills such as empathy, listening, a non-judgmental attitude and individualised care, which they perceived have sometimes become lost within nursing. They also expressed concern that the softer skills they valued were incompatible with 'academic' nursing."

[Griffiths et al., 2012, p. 125]

The sting in the tail is the perceived incompatibility with 'academic nursing'. Does the public not want their nurses to be smart, knowledgeable and well educated? We do not believe so. People are more discerning than some may imagine and patients and their families will quickly differentiate between a smart nurse and a smart arse. Being intelligent, critically thinking, well qualified and knowledgeable are valuable and admirable but the nurse who carries these qualities badly does so at his or her peril. In the plethora of current nightmare nursing stories we know of none where the complaint was solely that the nurse was 'too intelligent' or 'too well educated'. If the nurses so described were doing the other vital aspects of their job wonderfully well, then we suspect that for patients and families, their 'intelligence' or qualification level would never be an issue.

Where patients and public do take umbrage, with justification, is with the nurse whose attitudes and behaviours convey that they couldn't care less. Perhaps the public is not rabidly 'anti-intellectual', but simply struggling to comprehend, as Christina Patterson (2011) so painfully discovered, "Why nurses aren't kind" They cannot understand why someone lacking care and kindness would want to become a nurse in the first place. They cannot understand why a system of nursing education would admit them and then allow them to successfully qualify as an RN. They cannot understand how a hospital or health system indulges and tolerates such uncaring behaviour and lamentable 'nursing'. As they look around for reasons that may make sense to them they see a miasma of self-interest, self-justification and buck passing, with education blaming the corrupting influence of the service side, services blaming the 'ivory-tower' irrelevance of 'today's education' and governments worldwide thinking that austerity economics can be imposed upon their favourite political plaything, a health service, without any negative consequences. The words 'plague', 'all' and 'houses' spring to mind.

If these two systems cannot work together significantly more convincingly, we will assuredly be entering the 'Endgame' of this era's

nursing education system. There is no single quick-fix for this crisis in nursing and every nurse in practice, education, research and management needs to step up and play their part. Nursing education cannot simply clutch its Willis security blanket and wait for the health service culture to change, for the Francis Report recommendations to become reality, for the public to 'change their mind' about nursing, or for any other perfect alignment of societal and professional planets.

In an exquisitely articulated observation on the rise and effect of 'managerialism' (*not* management) in nursing, Bernie Carter wrote that:

"Our collective memory of nursing is being overwritten by a new programme of managerialism. Nursing is subtly and insidiously being reformatted, re-engineered, processed to become something which may be efficient and effective in a managerial, commercial and business sense but which is unrecognisable as something nurses or patients wish to engage with".

[Carter, 2007, p.270]

Does managerialism, we wonder, have an 'evil twin' called 'educationalism' (*not* education) that is similarly helping to overwrite and reformat nursing into something that may make curricular, professionalising and academic sense, yet which is similarly 'unrecognisable' to health services, other nurses and the patients, clients, families and communities whom we serve?

This crisis shows few signs of abating, as the latest update from UK Patients Association (2012) and the full horror of the second Francis Report (2013) suggests. Until the devaluation and downgrading of whatever we want to call 'fundamental care', 'basic care', 'core nursing', or 'skilled compassion' in Nursing and in our health services is arrested, the public and the media will rightly continue to ask why nursing and health care "cannot get basic care right" (Triggle, 2012). If our current system of nursing education cannot lead the movement for change, in lockstep with our clinical colleagues, then another system, as yet perhaps unimagined, surely will.

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