A traditional view of the nurse's role

Direct clinical involvement for every senior nurse was a 'radical proposal' put forward by Tony Carr, area nursing officer, Newcastle upon Tyne. He argues that the report separates co-ordination from professional functions and suggests that this is the road to abrogation of responsibility

IN SEVERAL places the report mentions the growing influence of nurses in the higher levels of management. Since the introduction of chief nursing officers in the late 60s and early 70s, and area and district nursing officers in 1974, the nursing voice has been heard much more clearly at management committee and AHA level. I believe this has been beneficial to the management of patient care services. It is fully appreciated that nurses' management structure and duty rotas enable them to see the weaknesses in patient care.

The Royal Commission has done its best to lay the myth that the Salmon committee and Mayston recommendations have swollen the number of nurses in nursing administration although I don't know if myth is quite the right word. My understanding is that medical staff in particular rationalise changes in nursing administration in a numerical way. I indicated in 'Nursing Times' in February 1975 that the number of nurses, in percentage terms, in administration had fallen consistently from 1966 to 1973 and used an appendix of the Halsbury Report to show this clearly. However, I did not persuade anyone that the figures meant anything and I think we shall continue to hear that good nurses are taken from the bedside and promoted into areas of administration.

It is very informative to talk to keen, eager nursing officers and ask why they left the ward to go into nursing administration. I asked one that very question last week. The reply was that she took the post because she could use her experience as a ward sister both to support the younger sister and to assess the standard of care on the wards and take appropriate action if she identified unsatisfactory nursing practice. The extra responsibility enhanced her view of clinical nursing and increased her personal motivation. She still felt fully involved in caring for patients. She taught learners and frequently assessed their practical examinations. When I asked about becoming a nursing officer for the extra pay she quickly enlightened me and said that ward sisters frequently earned more than she did. She had not opted out of nursing but had become more involved. Perhaps what medical staff are really saying is that under the matron type of administration which they wish to return to, they managed the ward sister and there is perhaps some resentment of the nursing officer having taken over the role. This is why I believe the myth I spoke of earlier will remain.

The Commission stressed the need to develop the clinical role of the nursing officer in line with the Salmon committee's recommendations. In a survey published in 'Nursing Times' about 18 months ago, I found that on average 25 per cent of a nursing officer's time was spent in patient care and in direct contact with the patient. However, until the senior nurse cares directly for patients acceptance by medical and other nursing staff remains a problem.

I would make what is for many senior nurses a most radical proposal. Every senior nurse from nursing officer to area nursing officer should have some direct clinical involvement. For instance, a divisional nursing officer might have particular interest in a special group of patients such as those with multiple sclerosis. She or he could become knowledgable in the latest treatments and nursing techniques.

Our medical colleagues have shown us how it could be done. Almost every teacher of medical students has a patient commitment. To do so 'keeps one's feet on the ground' and would allow senior nurses to exploit years of clinical experience. This is equally true for tutors of all grades. Instead of talking about a patient he knew ten years ago, how much better for a senior tutor to say 'I nursed a patient this week with this particular problem. Let's go and see her.'

Welcome proposals

Joint appointments proposed between clinical and tutorial posts are welcomed, but why not extend this to management? Although I have been asked to talk about management, I believe clinical practice and management should be complementary in the same person.

Although nursing is not specifically mentioned I have assumed it to be one of the hospital services to be co-ordinated by the administrator as mentioned in paragraph 20.27. The one criticism I have of the report, unfortunately it is a major one, is that its arguments are sometimes superficial. Those for the chief administrator are not at all sound. It is no more than an assumption that an administrator co-ordinating all the services will improve the service to the patient. Is this co-ordination to extend over 24 hours, seven days a week, including Bank Holidays? If it is not, I guess nursing will again be used as the unofficial backstop, unrecognised and, of course, unpaid.

I think the great fault in this argument is that the Commission did not go far enough into the organisation before it made its proposal. It stopped at functional managers at hospital level. Anyone visiting a hospital ward can see that a patient is given into the care of the ward sister. The doctor visits, diagnoses, orders treatment and goes away — the nurses remain.

Nursing has a strong hierarchy from nursing auxiliary to district nursing officers or area nursing officers in a single district area. There is a lot of criticism of the system but I suggest it is the most efficient, effective way to manage people.

The unit administrator would need a major increase in staff if he was genuinely to co-ordinate all the services. I hold to a very traditional and, to most, out of date view that all services impinging directly upon the patient — including domestic service, linen supply and catering — should not only be co-ordinated, but managed by the divisional nursing officer through the appropriate heads of departments. She has had practical experience of all the services, knows the difficulties and can often propose the solutions. What happens so often at present is that each of these disciplines have their own aims and objectives, and if these match up with the nursing objectives it is coincidental. The report separates co-ordination from professional responsibility. In my understanding, that is the path that leads to abrogation of responsibility on every side.