A nursing view

Deference, authority, flirtation, and stealth

SUE PEMBREY

How often it happens that we realise the value of someone only when they have gone. So it has been with the traditional ward sister. Are we too late to revive her? I am optimistic that we are not and I certainly hope not, for the good ward sister has probably been the single most important influence in nursing over the last 100 years. Her decline since the Salmon reforms has worried doctors and nurses but I detect signs of a renaissance in clinical nursing—the ward sister's *raison d'être*. How can we nurture this in the face of the inertia over nursing education

reform, the breakup of a traditional order, and the consequences of the Salmon nursing management structure?

Golden age

The pre-1960s era was a golden age for nursing. The opportunities to perfect clinical nursing skills were legion. Doctors could do comparatively little harm to patients; medicine was relatively straightforward so doctors generated less work than today;

and there were only occasional conflicts between technical "cure" nursing and maintaining the comfort of the patient, so the ward day could be largely devoted to internal nursing matters. The ward was a closed, stable unit where sister reigned supreme. Her relations with the consultant were the axis of hospital life and the care of patients recognised as the most important work. In those days the sister was unequivocally responsible and accountable for nursing the patients and organising the ward. Her prestige in the hospital, because she headed the most important unit, was considerable. Furthermore, she answered only to the head of the nursing services—the matron—and had direct access to her.

By the 1960s the ward was no longer a stable system; increases in medical specialisation and paramedical staff had brought a host of people to the ward, including a profusion of consultants from a multiplicity of specialties. In 1976 a study of 50 ward sisters showed that they were interrupted, on average, 64 times in the seven and a half hours they were on duty—many were interrupted over 100 times during this period. The old order, with opportunities for sister's calm and undivided attention for the patients, had disappeared.

Outside the hospital technological revolution and managerial efficiency were politically fashionable and the result was that nurses in the NHS were subjected to efficiency studies by non-nurses. One result from this trend we all know: in the late '60s the Salmon Committee's recommendations¹ on senior nursing staff structure were implemented. Unfortunately, these were introduced without the recommended pilot schemes, for reasons of political expediency at the behest of the National Prices and

Incomes Board. During this momentous change in British nursing those most affected, the clinical nurses, with no tradition of written work or research and with no forum for meeting outside the wards, were not in a position to influence their own future.

No latter-day Nightingale

Perhaps the nurses had been too good at their job, too interested in their patients, and too subservient to the doctors to have realised the importance of reorganising their professional training. Unfortunately, though the problem was recognised in 1947 by the Wood Committee,² nurses had no latter-day Florence Nightingale to campaign for them and there was no effective challenge to the traditional and by now inadequate structure of nurse training.

One famous tradition of British nursing is that the skills are learnt by nursing patients, a principle firmly endorsed in 1972 by the Briggs Committee on Nursing.³ A profession, however, cannot survive without constant development of its educational base; nurses, like any other group, need to review their practice, to develop new knowledge, and to explore ways of solving their problems, which, given the complexities of the NHS, include their self-management. There is no recognisable clinical career for nurses because there is no post-basic nursing education. Historically, nursing has been handicapped by having only specialist training and no common basic training in nursing principles. The Wood Committee had recommended a common 18-month training followed by specialisation. Nearly 30 years later in 1972, and with clinical nursing already overtaken by management training and "administrative" careers, the Briggs Committee again recommended a common 18-month training followed by specialisation. Last year, after a delay of seven years, the Nurses Act⁴—intended to translate the Briggs' proposals into reality—was passed and the first glimmerings of educational reform and the basis of clinical careers are in sight.

Fatal error

The management structure recommended by the Salmon Committee was a direct translation of a theoretical hierarchy of decision making devised in an industrial context by Paterson,⁵ who also happened to be a member of the Salmon Committee. The committee, however, made no attempt to analyse the nature of decisions exercised by different nurses or to explore the possibility that ward sisters' decisions were not less important than those taken by senior managers but were of a different order and thus did not fit in with those "line relationships" so relentlessly pursued by management experts. Furthermore, the sister's managerial responsibility and organisational authority—which hold the whole patient care system together—was specifically reduced. That was the fatal error and one which has been pursued with increasing energy throughout NHS reorganisation. As Revans has commented, "There is nothing like energy to make a bad plan worse."⁶

There are two interdependent systems at work in hospitals and changing one affects the other. The most important is the

Oxfordshire AHA (Teaching), Oxford OX3 9DZ

SUE PEMBREY, SRN, PHD, area nurse, clinical nursing practices development

care of patients; the second is the supporting structure of manpower provision, supplies, and so forth. The error was the failure to understand (though admittedly Salmon's terms of reference did not help) that the sister is not the tag end of the management system but the centre of the most important network in the hospital—the network of people concerned with the daily care and cure of patients, such as the doctors, nurses, technicians, porters, and relatives. The ward sister is at the centre of this negotiated order because she is continuously present “by the patient's bed” and it is she who translates the various contributions of all concerned into the daily pattern of care for each patient. The system is not a management system and the sister, as every doctor knows, fulfils her task through a curious mixture of deference, authority, flirtation, and stealth. The network is held together by the shared values of all who work for patients—and last winter's events show just how fragile it has become.

Resuscitating the ward sister

How can we resuscitate the ward sister? The broad aims are to increase her authority and accountability, to allow her to develop her education and career, and yet still to nurse patients. These aims can be achieved in the best traditions of NHS economics by reallocating resources.

Firstly, let us consider the structural changes needed. The head of the nursing service and the sisters must be brought together again so that they can talk to and help each other. A first step would be to promote nursing officers to wards. For example, a scheme for a ward-based nursing officer has already been successfully tried at Whipps Cross Hospital⁷ in which the most expert sister is paid as a nursing officer and given an extra staff nurse. This allows the sister to run her ward and yet have sufficient freedom to give special help to other wards. Other important changes should include having one sister only in each ward—so that everyone knows who is boss and the sister knows that she is entirely accountable—and one consultant responsible for each ward so that sister can give him her undivided attention.

Secondly, the ward sister will be offered some post-basic education and training, which is essential for clinical career development; a six-month joint board clinical course in the specialty of her choice; a teaching course; a visit to a centre of good practice; and the time and opportunity to think about and solve a clinical problem. A development here would be the

allocation of, say, 2% of the annual locally organised research funds to a clinical nursing project.

Thirdly, the sister's career development should be appropriately planned. On returning to the ward refreshed and with new skills the sister will be encouraged to take on special responsibilities and paid accordingly. Teaching will be one such responsibility. One way of improving the practical training and supervision of nurses, which is the key to good nursing, is to designate certain wards specifically as training wards. The Briggs modules of integrated theory and practice⁸ lend themselves to ward-based training programmes. The same principle of training wards could apply to the training of staff nurses and ward sisters. Two experimental ward-based training schemes for training ward sisters are in progress at Guy's and Whipps Cross Hospitals, each run by a sister and a ward teacher. Combined teaching and clinical nursing posts are a way of bringing tutors in nursing schools back on the wards and developing clinical careers for nurses.

More money for these special sisters could come from an ingenious “reallocation of resources” from the indirect patient care system practised by the DHSS. In the Department in 1978 there were 398 doctors and 53 nurses⁸—an interesting reversal of what happens nearer the “bedside,” where there are about 350 000 nurses and about 50 000 doctors. Each of the 398 doctors earns about £16 000 a year—each salary could immediately double (at £4000 pa) the salary of four ward sisters.

Finally, let me propose a cheap and practical way to launch the ward sister's renaissance: reinstate a proper time for coffee in her office. This simple ceremony can be highly cost effective, for it allows the different people concerned in the patients' daily care to work out with the sister how they can solve the patients' problems and ensure their comfort and care. And that, after all, is what the ward sister and the hospital are there for.

References

- 1 Ministry of Health, *Report of the Committee on Senior Nursing Staff Structure*. London, HMSO, 1966.
- 2 Ministry of Health, *Report of Working Party on Recruitment and Training of Nurses*. London, HMSO, 1947.
- 3 *Report of the Committee on Nursing*, Cmnd 5115. London, HMSO, 1972.
- 4 *Nurses, Midwives and Health Visitors Act 1979*. London, HMSO, 1979.
- 5 Paterson, T T, *Management Theory*. London, Business Publications, 1966.
- 6 Revans, W R, *Action Learning in Hospitals*. New York, McGraw Hill, 1976.
- 7 Wilson-Barnet, J, and Hancock, C, *Nursing Mirror*, 30 November 1978.
- 8 Clark, J, *Journal of Advanced Nursing*, 1979, 4, 205.

Staff accreditation and health authorities: BMA reminder

The Hospital Consultants and Specialists Association has written to RHA and AHA chairmen telling them of the association's affiliation to the TUC as an independent union and suggesting that the HCSA should be advised when the authorities require the name of the local HCSA representative.

Dr John Havard, secretary designate of the BMA, has also written to authority chairmen drawing their attention to the following points:

“Over the past two years the BMA has been obtaining accreditation with health authorities for its officials for purposes of the Employment Protection Act, the Health and Safety at Work Act, and for serving on joint consultative committees. We are anxious that the representation of hospital doctors should not be frag-

mented, and we believe that this view is shared by management.

“Accreditation of union officials, for purposes of the Employment Protection Act, is limited to officials of recognised trade unions. Recognised trade unions are those which are recognised for purposes of collective bargaining or those which have obtained a recommendation for recognition from ACAS. The BMA is the only union which is recognised by the Department for purposes of collective bargaining and HCSA has not obtained a recommendation from ACAS.

“As far as accreditation for purposes of serving on joint staff consultative committees is concerned, most if not all of these committees limit membership to unions represented on the General Whitley Council. HCSA is not represented on the General Whitley Council.”