Why nursing education has to change

Florence Nightingale said that “Reports are not self-exeating,” and nothing could be more true of the many reports on nursing education. The past 50 years have seen at least six—Athlone (1938), Horder (1943), Wood (1947), Platt (1964), Briggs (1972), and Judge (1985). All made remarkably similar recommendations, and none was implemented (apart from small changes to the margins). To expect too much from the latest report—Project 2000: A New Preparation for Practice—would thus be purely a “triumph of optimism over experience.”

But Project 2000 is different. Firstly, all sections of the nursing profession (a group not noted for its unity) appear to agree for the first time not only on the need for change but also on its key components. Secondly, the case for change this time supports the self interest of the service providers as well as the many aspirations of nursing visionaries. Thirdly, the proposals come from the body that has the legal responsibility for establishing and improving the standards of training and practice of nurses; it thus has the power to implement its proposals.

Project 2000 has come from the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting, the statutory body formed in 1979 by the amalgamation of all the bodies previously responsible for the education and regulation of the three parts of the nursing profession. It describes the changes needed in the training of nurses, midwives, and health visitors to enable them to meet the needs of the 1990s and beyond. The council also states its perceptions of the roles and responsibilities of nurses. Although Project 2000 is a consultation document addressed primarily to nurses, there is no doubt about the council’s commitment to change or about its main direction.

The proposals are radical, and the aim is to produce a registered practitioner (the word practitioner is used as shorthand for the cumbersome specification of the three separate parts of the nursing profession) who is competent to assess nursing needs, provide nursing care, and monitor and evaluate the care given. She is to be a “knowledgeable doer” with analytical as well as technical skills, capable of autonomous practice, and fully accountable for her decisions. A new aim she should be able to practise at this basic level in both institutions and primary care.

The core recommendation—for a two year common foundation course followed by one year’s specialisation—is a reasonable compromise between the “generalists” and those who have advocated direct entry into the specialties. It will provide a sound basis for the later training needed by new specialist practitioners, who will be the future ward sisters, team leaders, teacher practitioners, and clinical managers. This is the beginnings, at last, of a clinical career structure.

There is a clear commitment to preparing nurses who will nurse—in contrast to the position now, when patients are nursed (at least in hospitals) by unqualified auxiliaries and unskilled neophytes while the qualified nurses merely supervise.

The key change here—one advocated by every review of nursing education since the 40s—is an end to the dependence of the hospital service on student labour. Separation of the funding of education from the service budget and removal of the students from the staff establishment will enable the student’s clinical experience to be based on learning needs rather than the exigencies of the service. The education will become much richer, more community orientated, and based on a health orientated nursing model instead of the disease orientated medical model, which, quite properly, dominates medical practice. Those who once believed that hospitals could not survive without student labour now realise not only that students are no longer cheap (already only about 20% of their paid time is spent providing service) but also that an ever changing, unpredictable, and unskilled workforce is wasteful. Project 2000 may succeed where its predecessors failed simply because this time the costs of doing nothing are greater than the price of change.

JUNE CLARK
Special Projects and Community Nursing Officer, Lewisham and North Southwark Health Authority, London SE1 9RT

Blood transfusions and cancer: anomalies explained?

Had we the ancients’ respect for blood we should not think of a transfusion as the mere replenishment of oxygen carrying capacity. We can assemble an impressive series of the unexpected consequences of transfusing blood. Older rheumatologists tell of remissions in rheumatoid arthritis begun by blood transfusion.1 Recently spontaneous abortion has been shown to be preventable in some cases by a transfusion of husband’s blood.2 The effect of blood transfusion on renal allografts has been disputed ever since 1973, when Opelz and Teraski1 suggested, to much scepticism,