How to restore compassion to nursing

Ann Bradshaw reflects on inconsistency between the Francis report and recommendations from the nursing profession, suggesting ways to restore nursing's standing after the Mid Staffs inquiry

In 2011 an editorial in *The BMJ* with the title "We need to talk about nursing" commented on patients' concerns about nursing in the UK. The problem was not just heartless nurses or a lack of resources. The unanswered question was "how the education, altruism, and professionalism of large groups of healthcare workers had been subverted into a dismissive attitude to those in greatest need."[1]

Since then the Mid Staffordshire inquiry, chaired by Robert Francis QC, has reported.[2] Although the report affirmed much high quality, committed, and compassionate nursing, it also found that there had been a decline in standards. There was a negative attitude among some nurses, and relatives who complained were seen as difficult. Degree level nursing had been at the expense of experience of the basic tasks that all nurses should be able and willing to do.

Providing caring, compassionate, sensitive, and thorough attention to the basic needs of patients is, and should remain, the highest priority of any nurse. Fundamental care—such as lifting or washing a patient—is not simple, and requires attention and observation. The report recommended a review of nurse training to ensure practical elements were incorporated, and it suggested that consistent standards required national standards.

Here is a dichotomy. The report expects nurses to provide fundamental care. The Royal College of Nursing's Willis Commission, the profession's pre-emptive response to the Mid Staffordshire inquiry, is less clear.[3] Although the Willis Commission states that the core function of nursing will always be caring, it also states that nurses do not always provide this care themselves. In some situations they will supervise healthcare assistants and delegate responsibility while remaining accountable for that care. The commission sees the role of nurses changing, giving nurse prescribing as an example. Should the registered nurse be the primary caregiver, as Francis assumes, or the organiser and supervisor of the caregiver, as Willis suggests?

When asked in parliament if the problem of poor patient care was caused by short staffing or incompetent and compassionless staff, Francis replied that it was a combination of the two.[4] Although nurse education was not in his remit, Francis expressed shock at the lack of mandatory training standards. Giving evidence to the House of Commons health select committee, the chief nursing officer for England and the director of nursing at the Department of Health said they did not know the detail of undergraduate nursing courses in, for example, continence care.[5] In response to the inquiry both nurses have produced a vision statement on compassion to be included in all nursing educational programmes.[6] How compassion is attained, however, is not considered. Indeed, Nursing and Midwifery Council (NMC) education standards are vague, lacking detailed content and measures for assessment.[7]

Driven by what they consider to be the poor perception of nursing, and with the express objective of improving the public image, heads of university nursing departments set up a Lancet Commission.[8] Arguably however, this is not just a matter of image and perception.

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There has been a decade of concerns about the quality of care in UK hospitals: patients have been ignored, the regulatory systems have failed, and there has been a culture of denial.[9] So how might the nursing profession respond to these concerns?

Firstly, the North American system could be used as a model for the UK. Different training tracks would lead to a variety of nursing roles. All tracks, however, should start at the level of nurse registration: the registered nurse as fundamental caregiver. Then, if desired, the registered nurse could progress to advanced practitioner roles. The curriculum in all tracks would be primarily biomedical but include relevant humanities. Some aspects could be interprofessional—sharing medical training, for example.

Secondly, the NMC should set detailed national standards for nursing knowledge and skills, including teaching and assessment methods. This was the national system under the General Nursing Council from 1923 until 1977.[10] A prescriptive curriculum would also address Francis's concern about the lack of mandatory standards.

Thirdly, apprenticeships were considered the most effective method for inducting nurses into competent and compassionate care.[11] The move away from this method of training in the 1980s led to a distancing of nursing education from practice.[12] Currently student nurses are supernumerary in placements, and nursing lecturers are not required to work in clinical practice. Strengthening the links between education and practice could lead to significant change. If the NMC made it mandatory for nursing lecturers to be employed in clinical practice for a prescribed number of hours annually, and if student nurses became paid employees, this could be achieved. Not only would this improve staffing but lecturers and students, working together, could actively demonstrate commitment to patients' fundamental needs. Students would observe compassion and competence enacted by their teachers—not just in words but in actions. The missing art and science will not be found by talking about nursing, but rather will emerge in the praxis of everyday service to patients.

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Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

References are in the version on bmj.com.

Cite this as: *BMJ* 2014;348:g3310

NO HOLDS BARRED Margaret McCartney

Jeremy Hunt doesn't understand general practice

Name and shame; guilt and blame. The tools of Jeremy Hunt's Department of Health are striking in their medieval glory. Hunt's recent Daily Mail interview, on policy that his press office tells me is not yet official, revealed his plans that "family doctors found to be dismissing cancer symptoms as something less serious will be identified with a 'red flag' on an NHS website."[1]

However—whoopee!—"surgeries will be ranked 'green' for cancer on the NHS choices website if they quickly refer patients to hospital when they show possible signs of cancer. But if they miss too many cancer cases—or if patients have to return numerous times before being sent for tests—they will be classed as 'red.'"

This is what we have to contend with, colleagues: a health secretary who thinks that coloured labels on websites will miraculously resolve issues of clinical uncertainty, the troubles of diagnosing rare conditions, or, most potent of all, the underfunding of the NHS that means the average wait for a routine outpatient appointment is four and a half months.[2]

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Firstly, this is some way to announce policy to GPs, who are busy beyond belief and whose morale is already sinking. Reading about your future public flogging is no way to promote care and compassion in the workplace.

Secondly, the play of unintended consequences may be news to Hunt, but it is working practice to doctors. Name me a symptom that could absolutely never represent cancer; if GPs simply started referring all patients to hospital at their first appointment we could easily reduce the NHS, in one working day, to an overload of well patients—and do the sick an increasing disservice. But we at least would get a green star. Hunt's policy is incompatible with the use of time to diagnose or the judicious use of tests in primary care for people with symptoms.

Thirdly, the red flags simply don't distinguish between what signals a serious underlying cancer and what does not.[3] It would be far more rational to get rid of the two week wait, make outpatients wait a bit longer—but far less than 18 weeks—and allow phone calls between GPs and consultants to discuss patients' urgent needs.

Fear is a bad way to try to motivate a public service; adding humiliation to that is a nasty and evidence-free way to hope for improvement, especially with the existing funding deficit. A failure to understand what GPs do and the uncertainties with which we operate simply makes our work harder.

Scrutiny is often very good; transparency should be the norm. Auditing how new diagnoses are made can be useful. But none of this means that Hunt's bizarre, thought-up-in-the-bath ideas should be allowed anywhere near patients.

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Competing interests: See thebmj.com
Provenance and peer review: Commissioned; not externally peer reviewed.

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References are in the version on thebmj.com.

Cite this as: *BMJ* 2014;349:g4368

BMJ BLOG OF THE WEEK Richard Smith

The best doctors and their error

I'm listening to Sandy Ruddles (not her real name), an ordinary general physician who does some rheumatology, present a case, and I'm feeling some regret at having given up the sacred calling of being a clinician. Oddly, the case Sandy is presenting was disastrous, a catalogue of errors.

What impressed me was not Sandy's knowledge and technical skills, which are no doubt considerable, but her humanity. When it finally became apparent that her patient was going to die, Sandy went and told the patient and her family, and faced the anger and bitterness they felt. She described to them how the doctors, herself, but also the pathologists, dermatologists, and radiologists, had missed the diagnosis a year previously despite it being obvious in retrospect.

Sandy spent an hour every day talking to the patient and her family, and slowly they accepted what had happened and that the patient was going to die. When the patient transferred to a hospice, Sandy went to see her once a week until she died.

That fatal conversation with the patient and her family cannot have been easy, and many doctors would, I fear, have avoided it. Indeed, the pathologist, dermatologist, and radiologist did avoid it. One of Sandy's main messages to the young doctors at the meeting was talk to the dying, care for them, don't think that you are wasting your time on somebody who cannot be cured.

After the presentation I chatted to Sandy, and told her how impressed I'd been by her presenting such a disastrous case to the young doctors. Most doctors present cases that show how clever they are, rather than how stupid, but all doctors make mistakes—and learning from them, rather than denying them, is central to becoming a good doctor.

I told Sandy that I'd seen a professor of general practice tell a conference how he'd been operated on by a friend who had nearly killed him by making a mistake. The surgeon did not acknowledge the error at all until the professor said: "You nearly killed me. We can't avoid it. We have to talk about it." How awful, those in the audience thought, that the patient rather than the doctor should have to start the conversations that had to be had. Worse, the patient had to console the doctor.

Famously, good surgeons know how to operate, better surgeons know when to operate, and the best surgeons know when not to operate. I suggest that poor doctors run away from their errors, good doctors acknowledge and learn from them, and the best doctors not only acknowledge and learn from their errors, but journey with the patient through the pain they've created, no matter how uncomfortable the journey.

Richard Smith was the editor of *The BMJ* until 2004. He is now chair of the board of trustees of icddr,b [formerly International Centre for Diarrhoeal Disease Research, Bangladesh], and chair of the board of Patients Know Best

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