

Cruel Britannia: A personal critique of nursing in the United Kingdom

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ABSTRACT

The United Kingdom (UK) once led the world in nursing but because of the exigencies of the funding mechanisms of the National Health Service (NHS), it has fallen a long way behind other countries. We aim to raise awareness inside and outside the UK about the decline in nursing as a profession there. We are purposely contentious, in an attempt to raise questions, both for the UK and for countries which are recruiting British nurses who are leaving because of job losses caused by the funding crisis in the NHS. This paper discusses where the problems that have led to the decline have come from, where nursing is going and poses questions for the future. We hope that the UK government and those who influence the development of nursing will bring it back to the standard it once had.

KEYWORDS: politics; nursing; debate; nursing education; UK; National Health Service

FROM CRIMEA TO CRISIS

With Florence Nightingale, modern nursing began in the United Kingdom (UK) and ironically it is where it might end. We are two authors who come from different sides of the world, who have worked together and who are united by a common concern: the state of nursing in the UK. It gives us no pleasure to spread the bad news about nursing in the UK but our concern is such that we feel that people outside the UK need to know, and we live in hope that, where we have failed, others might help those who control UK nursing, and nursing education in particular, to come to their senses.

Modern nursing in the UK began with Florence Nightingale. While great respect is due to this remarkable woman, she has a great deal to answer for in terms of the plight in which UK nursing now

finds itself. We have worked in nursing in many countries and, for example, have recently seen busts and tapestries depicting Florence Nightingale in Hong Kong and Taiwan, but despite the common Nightingale heritage, we see none of the problems in these countries that beset nursing in the UK. Certainly, these countries have their problems; for example, Hong Kong is suffering a nursing shortage and an ageing nursing workforce in common with many developed countries (Watson, Deary, Thompson, & Li, 2008). What we are referring to is not these external manifestations of problems in the nursing workforce, but the internal crisis of confidence that seems to exist in UK nursing (Hall, 2004; Jukes & Gilchrist, 2006; Shields & Watson, 2007, 2008; Watson, 2001; Watson & Thompson, 2003; Webster, 2008). For example,

in the two countries mentioned, registered nursing is an all graduate profession, and one of us comes from a country where entry to the nursing register is all at graduate level. In the UK, specifically in England, this is not at present the case despite all nursing education being in universities. Scotland, Wales and Northern Ireland moved towards all graduate entry to the profession in 1999, but England decided to retain most nursing education at diploma level.

In was only in 2008 that the Nursing and Midwifery Council (NMC) (2008c) finally decided to move towards all graduate entry to the profession, to be achieved by 2011. The pressure for such change came not from within the profession, however, but from an unexpected source earlier that year in the shape of one of the, so called, Darzi reports – chaired by Lord Darzi, a senior UK medic (Department of Health, 2008) in which it was said (p. 19):

Nursing must attract the best quality recruits in an increasingly competitive labour market. Evidence suggests that a graduate registered workforce may help achieve these objectives. We will explore the opportunity and impact of a graduate workforce with key stakeholders, while we await the outcome of the Nursing and Midwifery Council's recent consultation on pre-registration education.

We are very pleased to report this change of heart by the Department of Health (DoH) in the UK and by the NMC; however, we hope that the damage is not already too great, that a truly graduate education will be provided, and that other aspects of nursing education in the UK, such as the admissions system to nursing – to be discussed below – are concomitantly amended. Whatever the outcome, it will be many years before the nursing profession in the UK is all graduate, even at entry to the profession, so these more recent changes do not negate what we have to say. In addition, it must be remembered that all funding for nursing education is provided by the National Health Service (NHS), and we wonder

how the NHS will support this higher standard, and therefore more costly form, of nursing education when it is already in financial crisis.

Florence Nightingale worked hard to create our profession; however, even her greatest fans would have to admit that she created a female profession and one for a certain type of female – with reference to character and morals – and a profession that was ostensibly subservient to medicine (Woodham-Smith, 1951). She was a product of her time, admittedly, and so was the profession she helped develop. However, we are long past that time, but it seems that the UK has not moved forward.

In this paper, we discuss the development of nursing in UK universities, the political situation which surrounds it and the present state of nursing practice, education and research. The paper is confrontational, and our intention is to raise awareness of the problems internationally, with the hope that nursing in the UK will address the problems and lobby government for necessary changes. Also, with the large migration of UK nurses internationally, fuelled by both the international nursing shortage and the current crisis in the NHS (Dreaper, 2008), potential employers of these nurses should be aware of the problems from which they have fled.

Whereas it might be argued that our international experience does not give us any privileged insights into what we see as the demise of nursing in the UK, it is unarguable that we have the right to express our opinions, and that we do so to encourage the critical thinking that is required to improve the future prospects of the profession in the country that is still seen in the West as the origin of professional nursing.

THE PRIMACY OF TERTIARY EDUCATION FOR NURSES

Most would agree that nurses should be educated to the highest standards possible. Legal responsibility for nursing care lies solely with the registered nurse (RN), and it follows that if one holds such heavy responsibility, one needs a high level of education. Rigorous evidence exists which shows

that a highly educated nursing workforce makes a difference to patient outcomes (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Duffield et al., 2007; Klein, 2007; Rafferty et al., 2007) and the consequences of poor education and mistakes are death and disability; therefore, the imperative to educate nurses to the highest standard, to provide them with ways to access the best evidence, the critical thinking skills to use that evidence safely and the skills to generate their own knowledge is mandatory.

Furthermore, educating nurses to the highest standards is cost effective. It is only through a degree that a student can adequately gain the knowledge needed to care for people in this time of highly technological health care, complex drug and treatment regimens, emerging diseases, complicated monitoring, convoluted management structures and difficult infection control. Nurses need to be able to communicate effectively with their patients, to advocate for them confidently, and this comes from critical thinking and life-long learning skills which ensure they can effectively find, use and generate evidence.

It is against this background that we voice our concerns about the way nursing is being decimated in the UK (Newman, 2007; Shields & Watson, 2007, 2008; Staff and Agencies, 2007a, 2007b). The country which was once the world leader in nursing has allowed nursing to drift backwards, and nursing has become politicised and subject to media pressure rather than critical and evidence based development.

THE UK NATIONAL HEALTH SERVICE

UK nursing takes place almost wholly within the NHS, and herein lies a significant problem. The NHS is the jewel in the crown of the UK welfare state system; a health service wholly run through taxation and free at the point of delivery. Even UK Prime Minister Margaret Thatcher was dissuaded from tampering with the NHS during her

period in office, which was characterised by the dominance of market forces and the privatisation of most of formerly nationalised UK industry.

The NHS is either the greatest achievement of UK welfarism or an unmanageable monolith, depending on the time at which one reads about it, what the latest crisis is and one's political perspective. It provides a comprehensive service to the UK population, from family doctors through to state of the art surgery; it is one of the largest employers in Europe, and the largest single group within the workforce is nurses. Therefore, nursing is the single largest expense in the NHS (NHS Employers, 2007) (and as the largest group, has enormous lobbying power which it seems to ignore).

NHS organisation will be considered below but the important point, with regard to UK nursing, is the fact that this is, essentially, the largest nationalised industry in the UK. As such it is almost directly run by the UK government through the DoH. Consequently, the NHS easily becomes and almost continually is a political football as a cursory search of Google shows¹. Nursing is regularly in the media spotlight in the UK and holds the dual position of being staffed by 'angels' (Watson, 2006) who, to many, are beyond criticism, or are seen as responsible for all that is wrong in the NHS. We emphasise that both positions are held in the collective mind of the UK population and this psychological dexterity is achieved through the view that individual nurses are beyond reproach, and that they are all doing a job that most would find difficult and many would not wish to do. Concomitantly, there is much in the media about poor nursing care, usually involving the suboptimal care of an aged relative and especially coming to the fore if the aged relative is the parent of a Lord of the Realm (Webster, 2008). This ensures that the catalogue of wrongdoing gets published, and herein lies the link between nurses and the UK government: hypersensitivity to adverse press coverage of

¹ http://www.google.co.uk/search?source=ig&hl=en&rlz=1W1GPEA_en-GB&q=nhs+political+football&meta=lr%3D. Accessed January 14, 2008, using search term 'NHS political football'.

anything that appears to tarnish its 'jewel in the crown'. Nurses help the jewel to sparkle; therefore anything wrong with nursing is felt directly by the government and the Secretary of State for Health (the person responsible for running the DoH) and, thereby, the NHS comes under pressure to 'do something about it'. In 1999 – a time when there was an upsurge in criticism of nursing care in the UK press – the then Secretary of State for Health, Frank Dobson, was well known for his dislike of university educated nurses and this was reported in *The Times Higher* (Loder, 1998). Precisely what was 'done about it' in 1999 will be explained below.

ORGANISATION OF THE NHS

Beyond the fact that the NHS is, more or less, directly run by the UK government, it is very hard to keep track of its organisation below the level of the DoH. When the first author (Roger Watson) moved to England from Scotland (where the NHS is organised differently) in 1999, the NHS consisted of a handful of regions. In England, the NHS was already organized around 'trusts' – acute and community trusts – and these require some explanation. Trusts were really the only visible manifestation of the Thatcher years in the NHS; they were an effort to break the NHS down into more locally accountable units and ones which would stand or fall by the extent to which they met their budget targets and did not overspend. It was a very low level effort to introduce market principles into the service. It did not work. Alongside this, since the late 1980s, there has been a concomitant effort to move care more into the community and away from hospitals (Griffiths, 1988). Despite the majority of care taking place in hospitals, this was seen as a potential cost-cutter and was accompanied by efforts to move people through the acute system as quickly as possible and back home to the comfort and expense of their own families (if they had one).

Primary care trusts (PCTs) were created in 2000 alongside community and acute trusts and these

were meant to be the units of organisation of the NHS, as well as being the most visible manifestation of the shift from acute to community care. In fact, financial roles were reversed, to some extent, because instead of the acute trusts being the direct recipient of significant proportions of the UK NHS budget, it was the PCTs that received the budget and they were commissioned to purchase care from the acute trusts – a manifestation of the changes that had taken place and an indication of where the power lay. In the meantime, the large NHS regions were abolished.

This rather 'chocolate boxy' view of how the NHS could be run was immediately undermined by the formation of conglomerations of PCTs where there was some division of labour between PCTs, and also some economies of scale which could be introduced. To cut a long story short, regional health authorities were recreated in 2007 but were now called 'strategic health authorities'. From the patients' perspective, nothing has changed. They were then largely unaware of the 'power to the people' experiment of PCTs and are now also blissfully unaware that this power has been removed. They are aware, however, that hospital acquired infection levels are increasing (Health Direct, 2008), waiting lists grow longer (Triggle, 2008) and that they are unlikely to see the same GP twice at their local practice (BMA, 2008).

FUNDING NURSING EDUCATION

As if the NHS did not have enough to worry about, it is also responsible for purchasing nursing education. The evolution of nursing education is outlined below, but the convoluted system whereby nursing education is purchased is related to the structure of the NHS and should be explained here. Historically, nurses were educated in the NHS or the hospitals which became the NHS and, as such, were employees of the NHS. Thus, the budgets for nursing education were administered locally by NHS training hospitals or groups of associated hospitals. Nursing moved from being hospital/NHS based, through

amalgamations of schools of nursing into colleges of nursing, which were located in universities, as will be outlined below, but the budget for nursing education remained with the NHS. To administer this budget, education consortia and later 'workforce development confederations' were formed to provide some economies of scale and commissioning across wide geographical areas (Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, 2007). These consortia/confederations were co-located with NHS trusts and were, to all intents and purposes, controlled by the regional NHS authorities in which they were located. The workforce development confederations survived the demise of the regions but have now gone with the advent of the strategic health authorities; therefore, purchasing power for nursing education is now, unashamedly, back in the hands of the largest unit of organisation of the NHS (as it stands at the time of writing). The take home message here is that the purchasing of nursing education by the NHS provides a direct link between the winds of change at the level of UK government and the delivery of nursing education by UK universities, where UK nursing education is now wholly located. This means that nursing education, uniquely for education delivered by universities (other disciplines are funded by the higher education funding authorities), has to be responsive to every UK government directive regarding health and nursing or face the consequences. The academic freedom of UK universities with regard to what is often their major single source of educational income – their nursing school – is severely undermined (Watson, 2006). The NHS funds, for nurses, only education and not research (Klein, 2007), (there are some funds available for nurses to do research through the NHS, but these are not direct NHS funds) the pursuit of academic goals by staff is severely restricted, and the professoriate in nursing in the UK is severely constrained compared with its counterpart in other disciplines (Thompson & Watson, 2006; Watson & Thompson, 2004).

NURSING EDUCATION IN THE UK

The UK has a long tradition of university level nurse education; the first university department of nursing was established at The University of Edinburgh in the 1960s (Weir, 1996) and soon followed by Manchester (Hallett, 2008) and Hull. However, the numbers of nurses educated at university was small and, in reality, these nursing students and graduates were an elite (Watson, 2001). There has always been plenty of prejudice against university educated nurses (Hallett, 2008) – it continues until this day (Hall et al. 2005) – but the truth about these early programmes was that they provided as much, if not more, clinical experience than their hospital-based counterparts; and the graduates remained in nursing, and remained in practice longer (Watson, 2001).

Until the late 1980s most nurse education (possibly better described as training) took place in hospital-based schools of nursing. However, the 1980s and early 1990s saw some significant changes; though these are hard to summarise precisely across the UK without more detail than there is space for here, because changes took place at different rates in Scotland and England. Scotland was quicker to move nurse education out of the myriad small schools of nursing that existed in many hospitals and centralized these into several colleges of nursing where the resources of the schools were pooled and the education was less like the former training. However, these colleges often remained in hospital grounds and were explicitly linked to the NHS.

Towards the end of the 1980s another change was imminent: Project 2000 was formulated (UKCC, 1987) whereby nursing education was to remain a 3-year programme, but that programme would be explicitly based on theory through an 18-month common foundation programme for all nurses, regardless of branch (there are four 'branches' of speciality and registration: general, child, psychiatric and learning disability), and the last 18 months of the programme would be specific to branch. There was no reduction in clinical hours, as these were redistributed across the

programmes. Most nursing education institutions, including the university departments, adopted this programme in the early 1990s. Project 2000 was a move towards a more university-style education for nurses while remaining at diploma level.

There were several evaluations of Project 2000 (Roxburgh et al., 2008), all ambiguous and interpretable in several ways. The enemies of the new style of training said that the nurse lacked clinical skills; the proponents said that they were no worse than before and, in any case, an intern year was really required (Bradshaw, 2001). All this took place under a Conservative government and was concomitant with a clinical grading system and several pay awards that increased nurses' salaries to reasonably acceptable levels; in one sense, nurses 'never had it so good'.

That was, until the current socialist (Labour) government came to power in 1997, ending 18 years of conservative rule. While nurses, many of whom would be considered to be natural Labour voters, must have helped to elect the Labour government and considered that they were in for a further period of 'having it good' and a rise in their esteem and professionalization, the supreme irony is that this government has presided over the demolition of everything for which the Project 2000 and university level educators of nurses had striven. A compounding irony is that all nursing education is now located in universities but most is at diploma level (Sastray, 2005). In addition, due to perceived public pressure and actual media pressure, the emphasis in nursing education has returned to 'training' with less emphasis on education (and this is reflected in nurses' perceptions of and language about their own development, as UK nurses usually refer to 'doing their training' rather than 'going to university'). At the same time, there is an increase in non-nursing care assistants at one end of the care spectrum and the development of nurse consultants, specialist practitioners and advanced nurse practitioners at the other end (Thompson & Watson, 2003; described in detail later). We hasten to emphasise that these are all worthy people

in their own right, but we contend that nursing, certainly as we know it, is disappearing in the UK...and we think this matters.

POLITICS AND NURSING EDUCATION

We have already alluded to the sensitivity of the UK government to any criticism of nurses and the link between government and nursing education has also been explained. Here we describe how media pressure led to the current state of nursing education in the UK. Some adverse media publicity about poor nursing care arose and there was a theme: nurses did not care as much as they used to; nursing care was poor; nurses were now educated in universities; therefore, university nurse education must be to blame. Essentially, the view arose that nurses were 'too posh to wash' (Hall, 2004). The level of analysis in these arguments was very shallow – no effort was made to ascertain if the nurses in question were university educated and, indeed, no effort was made to find out if these 'nurses' were actually 'nurses'. There has been considerable blurring of roles between nursing staff and unregistered health assistants who have recently and increasingly taken on a range of nursing tasks such as observation of vital signs. Also, there has been homogenisation of uniforms making it almost impossible to decide if a person is a nurse or a member of the domestic staff. However, the bad publicity and the prejudice of the Secretary of State for Health (Loder, 1998) were synergistic and the conclusion was reached that 'something needed fixing' – nursing education.

In 1999 it was fixed quite radically and, to implement sleight of hand, several things were changed at once: the nursing regulatory body was dissolved and its responsibilities reformulated (UKCC, 1999) and, as if by magic, the UK government drew up congruent proposals at the same time about how nursing education would be delivered and what it would be about (Department of Health, 1999). The story has been told elsewhere (Watson, 2002) but the outcome was skills based as opposed to an educational programme, and one

where the balance between practice and education was shifted in favour of practice. The only constant was that nursing education was to remain in universities. There was some protest by the leadership of UK universities, but not much (Finch, 1999), as too much was at stake financially.

THE EDUCATION OF NURSES NOW

Nursing students receive a bursary on which to live (Tables 1 and 2). This is paid by the NHS, and it is easy to see where their priorities lie when the amount paid to diploma students is almost double that paid to those reading for a degree (National Health Service, 2007). The degree student bursary is means tested, while the diploma bursary is not. Such inequities are hard to fathom, unless one connotes that the NHS is interested only in pairs

of hands to staff the wards as cheaply as possible, with little consideration for true learning, and certainly none for research. This flies in the face of the evidence about the increased safety of patients when the majority of nurses are educated to degree level (Aiken et al., 2003; Duffield et al., 2007; Klein, 2007; Rafferty et al., 2007). The inequities continue into employment, as a nurse who qualifies with a degree gets no better job, nor more pay than a diploma-educated counterpart.

Admission levels to university courses for nursing are of concern. While some universities, such as Birmingham and Manchester, take only the highest achieving students with superlative results in their A levels (tertiary entrance), the majority will take students with a much lower level of achievement (Sastry, 2005). Many universities accept students with five General Certificate of Secondary Education (GCSE) passes, the equivalent of Grade 10 in Australia. The low entry requirements result in struggling students who have been reported as having very low, in particular, numeracy levels (BBC News, 2000; Hall et al., 2005; Jukes & Gilchrist, 2006), something that would not be tolerated in other university courses.

Foundation degrees

Another reason for concern in nursing education is beginning. In the UK's target-driven political climate, the government has declared that 50% of UK citizens will have the opportunity to experience study at university (Kirkup, 2008). While there should be much more debate than there is about the sense of this, and more questions raised about the 'dumbing down' of universities to cope with the influx of students who would not, in normal

TABLE 1: 2007/2008 NHS BURSARY RATES FOR NEW STUDENTS (IN GBP; NATIONAL HEALTH SERVICE, 2007)

Payment	Diploma	Degree
Live in parents' home	6372	2231 ^a
Lodge elsewhere	6372	2672 ^a
Live in London	7443	3215 ^a
Dependent's allowances		
Spouse, partner, first child	2218	2510
Each subsequent child	512	512
Parents learning allowance	1050	1239
Means tested	No	Yes
Older students' allowance ^b	715	0
Initial expenses	55	0

^aThis allowance is for the first 30 weeks.

^bFor continuing students only in 2007/2008.

TABLE 2: ADDITIONAL WEEK'S ALLOWANCE (IN POUNDS) FOR DEGREE STUDENTS FOR COURSES LONGER THAN 30 WEEKS PER YEAR, FOR 13 WEEKS REMAINING IN ACADEMIC YEAR (NATIONAL HEALTH SERVICE, 2007)

Payment	Per week	Per year	Total possible payment ^a
Live in parents' home	52	676	2907
Lodge elsewhere	78	1014	3686
Live in London	100	1300	4515

^aCalculated by adding amount to annual payment in Table 1.

circumstances, be able to study at tertiary level, health care disciplines (other than medicine) have embraced such thinking. Enter the 'Foundation Degree'. These are being set up around the country in answer to this call (Open University, 2008). The worrying thing is that foundation 'degrees' are not degrees at all, but are at certificate level, and many of these are being set up to educate pre-nursing workers, that is, health care assistants and technicians. They are designed to be used as a foundation to further study, and we laud this aim, but they should not be called 'degrees'. Even the supermarket chain, Tesco (FDE, 2007), is setting up foundation degree studies for its workers. Employers in countries outside the UK may fall into the trap of employing such people as bachelor degree graduates, and certainly, at this stage, the British public does not understand the difference (Grimston & Robinson, 2008). How will they be able to distinguish between a nurse with, at minimum, a diploma level education, and a health care assistant with a foundation degree that has less academic standing despite its grandiose name? Patient care must suffer.

A SHORTAGE OF NURSES?

While the UK media give the impression of a nursing shortage which affects only the UK (thereby justifying the unethical and widespread practice of recruitment from *developing* countries to meet the needs of the NHS, which has widespread negative effects in those countries; Dean, 2005), it is well recognized that this phenomenon is international. Fuelled by the media, the British electorate demands both the highest standard of health care, and its free provision, which cannot be jeopardized by such things as an international shortage of a nursing workforce. Since 2001, 40,000 nurses have come from overseas, with most from the Philippines, South Africa and India (Bach, 2004). However in 2007, the NHS declared a crisis and 22,000 nurses lost their jobs across the UK (BBC News, 2007a). The nurses brought from developing countries to fill gaps in NHS staffing are feeling very insecure, as with the NHS funding crisis, even

new graduates within the UK have not been able to find work. In some places, in an egregious 'con job', nurses are being invited to come to the health services and work for nothing (Staff and Agencies, 2007a), or as health care assistants 'so they won't lose their skills' (Staff and Agencies, 2007b). No matter how desperate nurses are for employment, the unethical situation in which they could find themselves makes this a very dangerous situation for any RN. As well as new graduates not being able to find jobs, nursing academia has been affected in a flow-on effect. No promise of jobs means fewer students enrolling, and combined with a 40% cut in funding for education, universities have had to shed nursing academics, with several universities losing up to 78 nursing academics from their staffing complement (Newman, 2007).

NURSES' PAY

It is difficult to compare rates of pay across countries as costs of living differ, and so direct conversion from one currency to another is irrelevant. In England in early 2008, a newly graduated nurse earned GBP 19,683 per year (NHS Careers, 2008), with a small extra allowance for living in London (where life is very expensive), GBP 38 per year for registration fees, and 30% extra for shift work (Staines, 2008). To give some measure of comparison, at the date of writing, a bottle of Jacobs Creek wine costs approximately GBP 4, and petrol is over GBP 1 per litre outside London. In the UK, extra costs are incurred by expenses such as heating and winter clothing, factors that are not so costly in warmer climates. In 2007, nurses were given a pay rise that was below the inflation rate (BBC News, 2007b), in essence making nurses' pay go backwards. This has had a further follow-on effect, increasing the downturn in enrolments of nursing students, as nursing is not seen as an attractive career option. The Royal College of Nursing, which is mainly an industrial body, has been somewhat vocal about the pay issue, but has had very little to say about the unethical behaviour of trusts who have offered new graduates work at no pay.

HEALTH CARE ASSISTANTS

The NHS in 2006 stated that under a policy of 'widening participation', 40% of the health education budget would be taken from nursing, allied health and postgraduate medicine to allow those in the NHS who wanted further education to be able to receive it (Fryer, 2006). Under this agenda, anyone within the service who works as a domestic, cleaner, gardener, porter, laboratory assistant, clerical staff, etc., could be trained as health care assistants, and then be able to provide 'basic' care in hospitals. There seems to be little awareness that such 'basic' skills are the very ones for which nurses need the highest education level. While health care assistants may be able to, for example, make the bed of, and feed a stroke patient, they cannot assess the full effects of the illness on such a patient, from either a physical or psychological aspect, as they do not have the education to do so. Health care assistants are not educated to understand and interpret vital signs; nor to observe and assess patients while they undertake 'basic' procedures, and removing these tasks from nurses obviates opportunities for interaction and therapeutic communication. The rise of the health care assistant (auxiliary nurse, assistant nurse or nursing assistant) has been paralleled by them seeking their own autonomy and recognition; they now have their own professional journal, and often this body of the healthcare workforce is not accountable to the nursing profession. It must be recognized, though, that health care assistants are much cheaper workers than RNs (McKenna, Thompson, & Watson, 2008). In addition, technicians are allowed to expropriate nurses' knowledge and skills, and it is nurses, in the main, who are educating them to do so. Operating Department Practitioners (ODPs) are a good example. Many nursing schools in the UK run courses for ODPs, and most of the teachers are perioperative nurses, who cannot see that they are giving away their own roles (Shields & Watson, 2007).

OTHER ROLES

This rise of alternatives to nurses in the UK has paralleled changes in the time nurses have to spend

on what would once have been seen as duties beyond their nursing role, for example, some specialist and advanced practice and consultancy roles. While many of these are authentic nursing roles, and are therefore important for both patient and profession alike, such initiatives should be scrutinised to determine if they are truly nursing, or are being labelled to give nurses the feeling that their status is increasing when, in reality, they are encroachments into the medical domain, designed to compensate for the tasks which the medical profession are divesting, as their own roles expand due to increasing technology and medical and surgical possibilities. Nursing roles in the UK are expanding to include diabetes nurses, cystic fibrosis specialists; the list is very long, with such nurses providing valuable services. But what of the nurse who undertakes hernia surgery, or does endoscopies, or operates on patients with varicose veins (BBC News, 2004)? These are not and never will be nursing roles, and yet the NHS is encouraging such roles. After all, a nurse is much cheaper to employ than a surgeon.

MODERN MATRONS

In 2001, after a survey of perceptions about nursing held by the general public, the DoH brought in the 'modern matron' (Watson & Thompson, 2003). This moved nursing back 30 years, as cleaning and food delivery were integrated into this nursing management role. In this oxymoronic initiative, nurses are being pressured to resume domestic roles. The cleaning of wards as a nursing responsibility is a regression on improvements in the role of nurses since the 1960s, and can be construed as: (a) saving on costs of proper corporate services; and (b) a way to oppress nursing by those with vested interests in ensuring nursing does not become too powerful, namely politicians balancing budgets of the ailing NHS. In addition, one is left to wonder about the self-perceptions of men who willingly take this title, and also, it illustrates perfectly our contention that electoral and media pressure are more important drivers in policy than evidence-based health care.

THE ROLE OF THE REGISTERING AUTHORITY

The NMC, the registering authority in the UK, seems unable to resist these changes, and has fallen to political pressure from the NHS. The new 'The Code: Standards of conduct, performance and ethics for nurses and midwives' (Nursing and Midwifery Council, 2008b) makes no reference at all to research, in other words, the development and encouragement of research is not a priority. This is somewhat frightening, as evidence generation is an integral part of the expected roles of nurses in many countries (Australian Nursing and Midwifery Council, 2006; Singapore Nursing Board, 2006; The Nursing Council of Thailand, 2004). With research not afforded any place in nursing by the registering authority, it seems a little surprising that few nurses win (or indeed apply for) research grants from the Medical Research Council (or similar large grant funding bodies) and that the top universities in the country, Oxford and Cambridge, will have nothing to do with nursing. The status of nursing as a profession lies somewhere between the old fashioned respect for vocation, and the idea that nurses really do not need much education anyway. In fact, a member of the senior management of a university which teaches nurses told one of us that he believed that the UK needed nurses to understand the core medical issues, be hard working and have common sense. He went on to comment that if the entry levels were raised above the existing standards, the country would not be able to afford it as nurses would then have to be paid £60,000 per year. Such thinking may be characteristic of the attitudes held by other university managers who are making decisions about nursing education.

Nurses who come from overseas to work in the UK must, of course, register with the NMC, which creates another anomaly. If one comes from a country which is a member of the European Union (EU), the NMC cannot and will not ask for any proof of an ability to speak English. Consequently, people from EU member

states can register as a nurse in the UK with little English at all. Anyone coming from a country from outside the EU has to undertake an English language test in speaking, comprehension, reading and writing, even if their mother tongue is English. Australian, New Zealand, Canadian, American, Indian and other citizens who speak nothing else but English find they not only have to undertake these tests, but have to pay for them as well (Nursing and Midwifery Council, 2008a).

CONCLUSION

Historically, Britain led the world in the development of nursing and nursing education. In the last 20 years, it has not only lost that leadership, but has taken the profession back to an era when nurses were poorly educated, poorly paid and seen as either doctors' handmaidens or religious devotees. The NHS has encouraged this prevention of UK nursing keeping up with other countries. Consequently, the number of mistakes and blunders which are often laid at nurses' doors could more fittingly be identified with poor policy decisions driven by opportunistic politics and born of media and ill-informed electoral pressure. Nurses themselves have become so disempowered that they do not object. This is a sad state of affairs not just for the profession of nursing in the UK, but most importantly for the patients for whom they care.

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