A vocational crisis or merely changing our attitude to care?

In the September edition of *BJHM* Sir Roy Calne rightly criticized the standards of care and treatment received by many patients in NHS hospitals, especially in those units caring for older people (Calne, 2007). I would take his criticism further by extending it to include the extremely poor service offered to many older people being cared for in their own homes. He is also correct in seeing the need to return the power and control of nursing care to the ward sister (or the equivalent senior nursing post in the community) if we are to improve standards, address the serious loss of patients' dignity and deal with the growing number of hospital-acquired infections.

We know that the proposed 'deep clean' will be merely papering over the cracks. What is needed is overall management invested in the senior nurse responsible for a clearly identified group of patients and staff, and a cleaning service that is responsible to that manager. Cleaning staff, like catering staff, need to be employed by the NHS, not contracted out, with a fixed place of work where they feel valued, part of a team and understanding the special needs of that group of patients. Ultimately we should look to more involvement of patients in monitoring the delivery of non-clinical care such as catering and other hotel services.

The vocation of nursing

What I would dispute with is that we need to restore the 'traditional vocational nature of nursing'. I would argue that we have not lost it, but merely changed our attitude to giving care, in many cases taking on wider responsibilities without extra staffing and resources while still overseeing hands-on care.

Sir Roy is clear that patients need 'kindness and mutual trust as well as skilful care'. This is not new, and for many centuries has been grounded in the spirit of the 'vocation'.

We know from evidence in the Valley of the Kings how godlike the surgeons and skilled attendants were who provided care at temples such as that at Dendara. And Pavey (1951), writing of the doctrines laid down in Sri Lanka 200 years BC, documents the then King, Asoka, requiring sick attendants of both sexes to be 'devoted, of good behaviour, distinguished for purity, possessed of cleverness and skill, endowed with kindness, skilled in every service a patient may require, and ready to do anything that is ordered'. Apart from the devotion, that seems to be very close to what heads of schools sign as newly qualified students enter the nursing register. The Hippocratic Oath binds doctors to similar standards.

Religion and nursing

While that oath has for centuries defined the ethical behaviour of doctors, nurses were without an ethical code until the International Council of Nurses published theirs in 1963. This perhaps mattered less when nurses did indeed have a vocation, a religious calling that reinforced the doctrine of the church and was practised daily through ward prayers, chapel services, and chaplaincy visits and when those applying to train as a nurse needed a reference from a minister of religion.

The Christian religion documents women who receive God's call to nurse devoting their lives to the care of the sick or needy. As early as 451 the Council of Chaledon confined these Deaconesses to being either virgins or widows. Although as monastic communities grew the vocations of those caring for the sick merged with the even greater vocation of serving God the care of the sick remained paramount '…the care of the sick must be placed before every other duty, even the attendance at Office' (Scott James, 1953). Almshouses, hospitals and charitable foundations grew alongside abbeys and convents serving the sick, the poor, the dying and the traveller.

The vocation was not just the prerogative of the Christian religious. Richard the Lionheart received care from the physicians and nurses of Saladin when he was injured in battle. Out of their example grew the military nursing orders of the Templars and St John. Another example of the dual vocation? And Lanara (1996) describes the Byzantine hospitals which grew up in the Coptic church as being staffed by 'mostly nuns and monks as a form of prayer, a calling, a sacred service'. Nursing was seen as a form of contemplation with nurses being excused formal prayers if the demands of the sick were urgent.

The vocation or calling was an important part of nursing for many centuries. In Britain the co-vocation as a religeuse and nurse was to pass with the dissolution of the monasteries in the 16th century and nursing entered a dark age. Vocations began to be documented again in the 18th century with women such as Elizabeth Fry who took her commitment to serve from the Prophet Micah 'What does the Lord require of thee but to do justly, to love mercy and to walk humbly with the Lord'. Fry did not document an actual 'calling' from the Lord, but some 50 years later Florence Nightingale was to write 'on Feb 7th 1837 God spoke to me and called me to His service'. She was to record three other occasions when God called her to serve the sick.

Vocations were to persist in UK nursing for over 100 years. Only in the 1960s and 70s were we to lose the single nursing sister who lived in the hospital until retirement, the hospitals run more like convents with student nurses not allowed to marry, and qualified nurses who married denied promotion or even jobs.

From vocation to mission

Whereas this 19th and 20th century idea of a nursing vocation is founded in Nightingale other equally committed nurses, for example Mother Catherine Macauley (Nolan, 1991). Macauley took nursing nuns from Dublin and the East End to the Crimea and wrote not of a calling but of 'a mission, a plan of where I want to take my life'.

For me this is a clear cross-over from vocation to a life-plan, a goal one wishes to achieve for oneself not for God. Mother Macauley supports my perspective on nursing, namely that although modern day nurses rarely have a vocation in the original sense of the word they do have a mission, which sets their ethical basis for care.

Medical colleagues' ethical basis for practice has been defined for centuries. Perhaps this is why they have never explored the passing of the vocation. In 1982 Marguetta Styles, the president of the American Nurses' Association and later to become president of the International Council of Nurses, was to posit 'Has a code of ethics become the modern answer to a religious creed?' (Styles, 1982). For her it was the adherence to the code of ethics which made nursing more than just a job. Inglesby (1992) would disagree. She wrote 'a nurse no longer has a vocation, she has a profession', 'she is no longer dedicated: she is a professional', 'she is no longer moral, she is accountable'.

Neither Styles nor Nightingale nor Macauley would see these terms as alternatives. Whether nurses have a vocation, a mission or an ethical basis for care they are still expected to be professional, accountable and maintain the very best standards when delivering care. But in order to do this they need to be able to manage care and the care environment. For almost 20 years now, ever since the Thatcher government's tendering processes, nurses have not been able to manage the environment in which care is delivered.

They must be given back their responsibility for total care delivery if standards are to be improved.

Student nurses and doctors still enter the professions with a determination to make a difference and see the care of the sick, the mentally ill, the weak, as a privilege. They carry this commitment to serve and to care throughout their working life, despite the increasing constraints and pressures under which they work. At a time when we all walked closer to God our professions were respected and valued by those we served because of the understanding of vocations. To serve was an honour, and that brought respect. That respect, namely that we knew what we were doing and could be trusted to do it, extended to politicians and the media. There is no doubt it has become more difficult to care in a climate of excessive paper accountability and media blame.

We all recognize that patients need to be treated with dignity and to be valued. Professionals need that respect and valuing too. Neither doctor nor nurse is happy with substandard care and treatment. But, as Peter Carter, Chief Executive Officer of the Royal College of Nursing said recently 'To provide the highest level of care, staff need to feel valued, be fully supported and be given resources' (Doherty, 2007). We also need the press to acknowledge the good things nurses and doctors do, and the government to ensure that we have the resources we need to care properly.

Recognizing commitment

It is not the passing of the vocation that has lead to the crisis in care. It is the failure of 20 years of government, of both parties, to give nurses the tools to do the job, to trust us to manage care, to supervise those who work with us to deliver it, and, dare I say it, the financial reward that values the 24 hours a day 7 days a week commitment. After all, as Margaret Sparshott, matron of the Manchester Royal Infirmary and president of the Royal College of Nursing, said, in 1930, 'the nurse is the one who is allowed to see patients at their weakest moments, to tend friends in their darkest hours and to bring unseen strength by the giving of her own strength'.

Surely any profession with this commitment to health-care delivery should be given responsibility for doing their job, the resources to do it properly, the salary that values the commitment they have made and the recognition from the government, the media and the public that they are the real leaders of nursing care. **BJHM**

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KEY POINTS

- Although for many nurses the sense of vocation has gone there is still a commitment to care.
- This commitment is bound in the ethical basis for practice.
- In order to deliver the best possible quality of care nurses need to be given back the responsibility for managing house-keeping services.
- These services must meet the demands of care not the efficiency (cost constraints) of management.