Whither Florence Nightingale?

John Hyde

Status in the social hierarchy has become so all-important to Australians that many of us have our incomes determined more by it than by the usefulness to other people of what we do.

Thus, a lazy and incompetent professor is paid more than a dedicated lecturer. Train drivers, irrespective of individual competence, are paid so much; firemen so much else. Carpenters are likely all to be paid the same award wage irrespective of what they build, and so on. If, on the other hand, a carpenter should fit a tap, he will probably precipitate a strike.

Australian Bureau of Statistics figures show that workers with the status of trade union member earn more than non-unionists and those with the status, public employee, earn more than those on private pay rolls. This is the case even though non-unionised, private-sector employees probably produce more of value than their counterparts. Generally, irrespective of output, university graduates are paid more than non-graduates, and so on.

The tendency to reward status rather than production is nowhere more evident than in the health-care industry. The latest issue of the AIPP publication *Clear Thinking* asks: "Whither Florence Nightingale?"

Most nurses are employed in the public sector where status is nearly everything. Until recently they enjoyed more respect than status. They were central to patient care, often rendering services to the ill which were inherently unpleasant to perform. Their skills---that is, the skills which they had in larger measure than others within the hospitals---were not easily learned from books. They brought these special skills with them to their calling and they learned them from experience in the wards. Thus nurses were skilled tradespeople rather than professional people. In a rational world they would have been no less valued for that, but, then, the public sector is seldom quite sane.

Nurses earned less than the doctors, dieticians, occupational therapists, physiotherapists and others with whom they worked. This was the case, even when they patently carried more responsibility, worked harder, had more subtle skills and---which is the relevant point---contributed more to patients' health. The government employment system, rational only in its own terms, had accorded them lower status and rewards than the "professionals".

One is tempted to say that nurses had a legitimate gripe. Still, they remained free agents. They, unlike patients and taxpayers, could abandon the hospitals. Many did. This caused a shortage of nurses which placed power in the hands of the nurses' unions at just the time when the feminist movement, which is hung up on status, was at its most influential, and Medicare was encouraging patients to flood into public hospitals. Some nurses took the opportunity to promote a professional nursing service and Senator Susan Ryan, then the Minister for Education, decided that nurses should be trained in universities.

In Western Australia, hospital-based nurse training was phased out in 1985. Nurses now pay lip service to a research-based discipline but neglect the rigours of quantitive method. Today's trainee nurses may, however, study silk-screen printing as an optional subject.

Nurses have become self-appointed diagnosticians. They shamelessly borrow jargon. A nurse was required to describe a patient with a painful broken leg thus: "He has undergone an alteration in his comfort state, related to a change in skeletal integrity." This gobbledegook is the new "nursing process"---if you please.

In search of status, nurses are refusing to undertake menial tasks which are now left to underlings. To keep clinical nurses at the bedside, all nurses with seven years experience or more were promoted to a level equivalent to the former level of charge nurse. Each nurse is now required to act as shift co-ordinator on a daily, weekly or fortnightly roster. Discontinuity, together with the unsuitability of some nursing sisters for the role of charge sister, has led to conflict and confusion. No-one now has continuing responsibility for the patients and the only person on the ward with on-going information about a patient may, in fact, be the untrained ward clerk.

At the same time as this was happening, in WA, which is roughly typical of other states, nurses achieved a 38 hour week (cost $9.3 million); a ten hour or longer break between shifts (cost $5.5 million); no non-nursing duties (cost $5.5 million); and better accommodation (cost $4.7 million). This was followed by a $70 million package over three years, and, in 1987, a 22% pay rise. I have heard it said that the decision to "professionalise" nursing was the most expensive single decision of the three Hawke Labor Governments.

It has not worked. Nurses have gained status but at the cost of respect. Nurses are trained to administer more complex therapies and to better assess patients but at the cost of basic nursing---that is, at the expense of those services which they rendered better than anybody else in the hospital. Many nurses see their leaders' goals as irrelevant: they want to nurse.

We should not be surprised that professionalisation is not working. It was tried in the United States ten years ago where it has not made nursing a more attractive job. It is probably no coincidence that the US has been recruiting UK and Australian non-tertiary qualified nursing sisters.

If individual nurses could be rewarded for their productivity, none of the problems which have resulted from the nurses' scramble for status would have arisen. In the delivery of health care there is, however, no objective measure of productivity. Only a market of competing buyers and sellers of nursing skills could be both efficient and fair. But the government destroyed the market for health services, and now must haggle with unions about the relative status of different callings. Meanwhile patients and taxpayers bleed.

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