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Being a real nurse — Concepts of caring and culture in the clinical areas

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Summary In this paper we discuss the issues of caring and culture in practice settings and how they affect student nurses in their endeavours to learn how to be a 'real nurse'. Drawing upon differing conceptions of 'caring' we discuss the notion as a pivotal factor in becoming a nurse.

We examine the degree to which boundaries are changing, not least those in which students seem currently to define the bedrock of physical and emotional care as belonging to health care support workers whom they will merely supervise. Complicating this picture are developments in medical and nursing boundaries which may, or may not help to 'professionalise' nursing.

We conclude by arguing that complex cultural norms and the negotiated order of health care need to be properly recognised by curriculum developers if, within contemporary higher education nurses are to be fit for purpose and practice.

Introduction

In this paper we will explore the concepts of caring and culture in clinical areas within the United Kingdom (UK) and how they affect student nurses in their endeavours to learn how to be a real nurse.

There has been much written regarding nurse education and the socialisation of student nurses in clinical areas (Olesen and Whittaker, 1968; Orton, 1981; Melia, 1987, 1997; Ogier, 1989; Castledine, 1995; Bradshaw, 2001; Spouse, 2003). However, students still struggle to understand their clinical roles and to become accepted and central members of the established ward team. They enter the clinical areas desiring to learn how to be a qualified nurse yet they often complain that they are being '*used as a pair of hands*' or '*being treated*

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as an unqualified member of staff', rather than working alongside the qualified nurses. We therefore need to ascertain the definition of a real nurse.

What is a real nurse?

Henderson (1991, p. 21) argued that:

'The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he(sic) would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him (sic) gain independence as rapidly as possible'.

She continued to argue that no one member of the team should make heavy demands on another member of the team that prevents them from being able to perform their unique function. All team members should consider the person (patient) as the central figure and should realise that primarily they are all there to assist them. However, Henderson (1991, p. 22) stated that '*the more one thinks about it, the more complex the nurses' function as so defined proves to be*'. She contended that the nurse is, and should be legally an independent practitioner who is able to make independent judgements as long as he, or she, is not diagnosing, prescribing treatment for disease, or making a prognosis. These, she argued, are the physicians' functions. What the nurse maintains is the authority on nursing care.

Perceptions of a nurse

The role of the qualified nurse is constantly evolving to a point that they no longer spend a large proportion of their time at the bedside but rather leave these duties to the unqualified staff (Allen, 2000). Arguably, at least on general wards, qualified staff have rarely spent a large proportion of their time at the bedside. This has always been the domain of the unqualified staff. For over a hundred years these were the student, and later pupil nurses. More recently, since the advent of 'supernumerary status' these unqualified workers have been health care support or assistant staff (Thornley, 2000).

Perceptions of what being a 'real nurse' is have often been based on images of nurses held by the general public. Foskett and Hemsley-Brown (1998) argue that historically nursing has relied on an occupational gender separation to sustain its workforce. The perception of it being a traditional female job has led to nursing being perceived as work based on common sense, 'women's work', primarily an emotional phenomenon that is less objective than the scientific, curative work of male dominated medicine (Howard, 2001; Phillips, 1993). Media stereotypes often portray nurses as sex objects, obediently supporting medical practitioners, subservient as the (male) doctor's handmaiden, with little independent professional and academic knowledge (Howard, 2001). These have contributed to a pervasive perception that the nurse's role is supportive, passive and subordinate to that of the doctor (Foskett and Hemsley-Brown, 1998).

Cunningham (1999) reports that the doctor's handmaiden image remained particularly potent for nurses. Whilst the function of nursing is changing with the advent of the specialist practitioner and nurse consultant roles this has led to questions as to whether this is an up-market version of doctor's handmaidens. These advances in nursing practice could also be viewed as problematic in other ways. There could be an even greater loss of power as nurses expand their roles and as a consequence lose a their focus on nursing. This loss of focus can be argued to be occurring through nursing allying itself to a semi-professional mini-doctor role, somewhat like a technician (Jinks and Bradley, 2003).

With the continuing changes in the role of the qualified nurse it is all but impossible to offer a generic definition of their role. It is no wonder, therefore, that the students on clinical placement become confused and frustrated as to what their role is and how they should develop their skills and knowledge base to ensure that they are practitioners who are '*fit for purpose*' and '*fit for practice*' on qualification.

Perhaps what nursing should be interested in is the care of the patients. Nurse education and training programmes seem to need to identify how the students can care for patients while applying the best available research and evidence and working in unison with relevant members of the multi-disciplinary team. Wade (1999) suggests that nurses should be concerned about doing the right thing for the patient at the right time, while engaging in collective enterprise with other health care professionals. The notion of caring as being a pivotal factor in becoming a nurse is an issue that requires some discussion. The argument about 'what is caring?' and who should do this care is redefining health and even social care professional boundaries in the practice settings.