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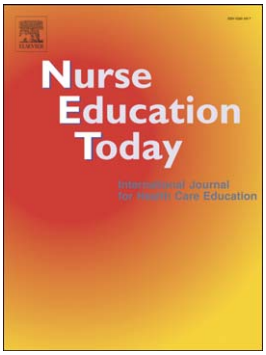

Willis and the generic turn in nursing

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Willis and the generic turn in nursing

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Over the past months a series of articles in the journal have drawn attention to concerns about aspects of the quality of nursing care in the UK (Paley 2013, Darbyshire 2013, Rolfe & Gardner 2014, Roberts & Ion 2014). Jackson et al's (2014) recent review of the whistleblowing literature indicates that these concerns are more widespread. This view is echoed by Ion et al (2015) who noted that student nurses from across the world encountered poor practice while on placement.

In the UK this has led to a good deal of reflection with some arguing that the problem is a function of chronic underfunding of health services and a workforce which is understaffed (Randall & Mckeown 2014)For others, the issue is tied to the way in which nurses are educated. This is the view taken by Lord Willis whose Shape of Caring report was published in March (Willis 2015).

Among a number of other recommendations the Review calls for a reappraisal of the UK's pre-registration specialisms of Adult, Mental Health, Learning Disability and Child Nursing. Specifically it makes the case for ending the current approach to nurse education in the UK in which students to specialise in one or other of these four fields at the start of their training, in favour of a generic approach with the first two years of the degree programme spent together, with specialisation not happening until the final year. This proposal is not dissimilar to that previously tried in the UK under Project 2000, and echoes the approach used in areas of Europe, as well as in North America and Australia. In USA mental health nursing is undertaken at masters level after a generic preparation.

While we accept that nurse education needs to change and evolve, not least because there are huge challenges on the very near horizon – namely continuing economic austerity, the need to address health inequality, and the time bomb that is our ageing population with comorbidity being the norm, we reject the simplistic view in Willis that a return to genericism will solve these difficulties.

There are a number of reasons for this; including the observation that generic nurse education has already been judged to have failed in the UK in its previous guise of the Common Foundation Programme, where it was felt to privilege adult nursing at the expense of the other specialisms – a view echoed in Hazelton's (2011) comment on Australia's current situation. It could of course be argued that a reformed generic approach might be different and that somehow, Deans of Nursing can be persuaded to forgo the economies of scale that can accrue when all students take the same classes for at least two years of their education. Even if we accept this unlikely scenario, we are left with some fundamental concerns about the appropriateness of the turn to generic nursing.

First amongst these is the issue of what problem this solution is aimed at solving? The much discussed absence of compassion in modern nursing care is one of the issues raised by Willis. It would be impossible to argue against the central nature of this quality in all settings. Less clear, however, is how a generic approach to nurse training will foster this in way which the specialisms cannot. We would argue that compassion and the attendant skills and qualities of critical thinking, ethics and accountability are best taught in small classes where students can explore in depth the subtle nuances of different approaches to patient care in the specific context of their role as caregivers. This is not to say that generic programmes cannot provide this rather that they have no special quality that will ensure that they do – some might argue that their tendency to large classes mitigates against this resource intensive form of teaching.

On the face of it, generic education might also resolve some of the problems that have been identified in relation to the physical health needs of people with long term mental health conditions and conversely the psychological needs of those with physical problems. Sadly there is no evidence to support the view that a generic nurse will improve things. Moreover, the common sense argument that generic training will upskill all nurses is easily countered by the claim that it leads to the unskilled Jack of all trades. We would also argue that the notion that mental health and learning disability nurses should be a bit more like adult nurses and visa-versa is very misplaced. Instead

colleagues from mental health and learning disability should be skilled in providing standard nursing care, which includes competence in some aspects of physical health. We agree that Adult nurses need some understanding of fields outside their own, but that this is overshadowed by the need to develop skills in the psychological care of people who are physically unwell – a very different set of skills to those required to work with people with long term mental health conditions or learning disability .

Finally, for at least two of the current specialisms, the generic approach holds particular fears. Over the past few decades learning disability and mental health nurses have worked hard to shed the image of the custodial asylum attendant. In tandem with this has come a developing rapprochement with service users and a commitment to social models of care. In mental health care this can be seen in the development of recovery focussed care, while in learning disability Wolfensberger's (1972) normalisation theory has had an equally radical impact. While adult nursing has also changed a great deal in the same time period, it has not undergone the seismic shifts in philosophy and approach to care that have taken place in these two disciplines. For very good reason, adult nursing remains committed to a biomedical vision of illness which, while cognisant of the importance of a holism, is tied to a physical approach to care. Conversely concepts such as illness are increasingly marginalised in both learning disability and mental health nursing. Put simply it is difficult to see how after two years spent discussing a biomedical framework for understanding distress, a socially orientated approach to nursing can simply be bolted on.

In summary, our view is that the turn to generic nurse education will not put right nursing's failings. Where these exist, we need to have a clearer sense of what the problems are and what will improve them – the evidence - before embarking on wholesale change which, unless we take these basic steps, may worsen as opposed to improve the situation. While wholeheartedly endorsing the need for change, and a stronger emphasis on post-graduate education, we reject the notion that genericism will solve the problems we face.

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