

GUEST EDITORIAL - Judith Townsend, BAppSci, MA, MHE, RN

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HEALTH-EDUCATION PARTNERSHIPS: A REFLECTION ON PROFESSIONAL AND PERSONAL PAST

In 1984 I joined the University of Western Sydney, Australia, as a scared, but proud and committed nurse academic. Three things became immediately evident. Firstly, there were few programs for university staff to ease their transition from clinician to academic. Many faculty staff remained confused and distressed about their primary roles, their loyalties, their own identities - that had been established over many years. They grieved for their loss of standing and certainty as clinicians and were uncertain of the expectations of their new institutions. I suspect considerable confusion remains.

Secondly, there was considerable ignorance among health and community agencies regarding their roles and responsibilities towards students during clinical practicums. There was a resistance to engage with the new programs that led to poor cooperation and antagonism by all parties. Tension between those who educate and those who provide clinical service about roles and responsibilities still exists and does little to achieve the espoused goals of both sectors.

Thirdly, nursing and health services leaders could or would not embrace a new style of graduate that necessitated changes to their values, processes and structures. New graduates were frequently perceived as threats. There was a pervasive sense that they needed to be disabused of their lofty ideals and inducted into a conservative workforce as quickly and completely as possible.

A scan of many submissions to the recent Australian Government commissioned *National Review of Nursing Education* has caused me to wonder to what extent the workplace has welcomed change in nearly 20 years of nursing in the higher education sector. It seems to me that the rhetoric is unchanged in 2002. University submissions continue to use phrases like 'unrealistic employer expectations' and employers speak of 'lack of work readiness'. Much has been written about the need for nursing leadership and its potential to achieve highly desirable goals. Indeed, the Institute of Nursing Executives of New South Wales and the Australian Capital Territory recently argued that:

Effective nursing leadership and management is essential to promote a culture in which there is a consistent philosophy, shared professional values and systems of support and communication. Therefore we need to devote significant energy into management development that moves managers away from their current contemporary (aggressive-defensive)

management styles that influence poor recruitment and retention of nurses and promotes a negative organisational wide culture. A culture within nursing and healthcare of mutual respect, teamwork and positive reinforcement must be promoted.

Despite this, my perception is that the conditions I met in 1984 remain in force in 2002. Unexpectedly, I recently spent several weeks in a large Sydney teaching hospital being prepared for the removal of a pheochromocytoma. As a clinical RN for 20 years and a nurse academic for the next 10, I took a professional interest in the standard of my own care.

Over these weeks the reality of the care context became obvious. As I was prescribed alpha- and beta-blockers, I was increasingly unsteady and bed bound and had ample opportunity to observe and reflect on my experience.

I found that while conversations with my physician were illuminating and the medical students were hungry to learn and listened to me attentively, the expert caring I believed had made me a good clinical nurse was a distant memory.

On the two occasions when students and their supervisor came from one of the assigned universities, they were still treated as a race apart - they still felt like interlopers and outsiders. They too were hungry to learn and were extraordinarily grateful for my patience and attention. Their pensiveness and thoroughness were certainly not interrupting any other nursing care. And, at the end of each day, their supervisor expressed heartfelt thanks. They didn't know I was a nurse and academic. I was simply another patient, but the supervisor and several of those students visited me postoperatively in their own time, both to see how I was and to complete their own learning.

However, except that someone gave me medication umpteen times a day, I would not have known there was an RN on the ward. I experienced the impact of a highly casualised workforce that struggled to maintain its ideals within an uncompromising system. Where was the core nursing workforce? Where was my continuity of care? Where was the nurse who could sit down and talk with me, listen to my real fears, explain what I might expect in intensive care postoperatively?

Submissions to the recent *National Review of Nursing Education*, suggest there is general agreement among nurse clinicians and nurse academics, and among universities and health service providers that initial

registered nurse education should properly remain in universities. But there is also strong feeling that there is a need to strengthen the partnerships between universities and health agencies, to enhance communication and strategic collaboration, and to improve the clinical focus of educational programs in ways that promote work readiness. Why has nothing changed?

Earlier this year, Australian Reserve Bank Governor Ian Macfarlane issued a plea to the political class to halt the decline in Australia's intellectual reserves. Macfarlane warned that university policy is not just about access but excellence. He talked of the need to overthrow long held conventions, presumably anti-elitism, 'more rife than ever'.¹ Although Macfarlane was talking about the wider economic and educational systems, the sentiments apply equally well to nursing practice and nursing education. Eighteen years after nursing education began its transition to the tertiary sector, issues arising from miscommunication across the learning/practice divide seem little closer to resolution.

After all this time, why is the need to effectively manage the nexus between education and practice so frequently spoken of as essential, but so poorly understood

or implemented? Does it have something to do with Macfarlane's notion of anti-elitism? Are university programs and nurse academics still perceived as living in ivory towers, divorced from the 'real' world? Are health care providers, organisations and individual nurses still not convinced of the efficacy of university education? Is there a perception of intellectual snobbery by universities? Is it inverse snobbery by clinicians? Is it patch protection by both sides? Is it economic rationalism? Is it a media beat up? Or is it that health and education are different political portfolios and will compete forever for the attention of their separate ministers, and for funding from the ever-shrinking public purse? Whatever the external happenstance, the only genuine form of resolution will come when we join forces, stand up to be counted, and put our own houses in order.

We have so much to lose by keeping our hands at our sides and our eyes averted. But so much to gain by breaking out and joining forces for the benefit of all - ourselves, our colleagues and our clients.

REFERENCES

Kelly, P. 2002. *Weekend Australian*, 6-7 April 2002. 17.