Enferm Clin. 2019;29(2):131–135

Enfermería Clínica

www.elsevier.es/enfermeriaclinica

SPECIAL ARTICLE

Are planets lined up for nurses to cross the mirror?☆

Juan F. Hernández Yáñez

Sociólogo, consultor independiente y divulgador, Las Palmas de Gran Canaria, Spain

Received 29 June 2018; accepted 9 August 2018
Available online 13 November 2018

KEYWORDS
Nurses;
Advanced practice nursing;
Demographic transition;
Chronicity and frailty;
Healthcare

Abstract Since the publication in 2010 of the document 'Nursing in front of the mirror: myths and realities', the nursing profession has worked hard to study and recognise its myths and realities. Now is the time to ask whether the profession is yet in a position to stop standing in front the looking glass and, like Alice, cross through.

PALABRAS CLAVE
Enfermeras;
Enfermería de práctica avanzada;
Transición demográfica;
Cronicidad y fragilidad;
Atención sanitaria

¿Están alineados los planetas para que las enfermeras crucen el espejo?

Resumen Desde la publicación en el año 2010 del documento «La enfermería frente al espejo: mitos y realidades», la profesión enfermera ha realizado un trabajo de análisis y reconocimiento de sus mitos y realidades y es el momento en que necesariamente debe hacerse la pregunta de si ya está en mejores condiciones para dejar de mirarse en el espejo y, como Alicia, cruzar a través de él.

DOI of original article: https://doi.org/10.1016/j.enfcli.2018.08.003
☆ Please cite this article as: Hernández Yáñez JF. ¿Están alineados los planetas para que las enfermeras crucen el espejo? Enferm Clin. 2019;29:131–135.
E-mail address: Juherya@gmail.com

Introduction

In 2005, the healthcare community had already started to realise that predictions of *glass-half-empty* were already coming true, initiating what is now termed the ''end of the disease era''.[1] The geriatrician, Kenneth Rockwood, refers to the paradoxes of elder care,[2] warning that when excellent cardiologists, pneumologists and nephrologists were faced with patients with cardiovascular, respiratory and renal disorders at the same time, they would declare them untreatable, and concludes: ''Geared to the sophisticated treatment of single problems, our system doesn't accommodate the complexity of caring for frail elderly patients, even though that is where much of our demand comes from''.

Also in 2005, the prestigious doctor and academic Thomas Bodenheimer published the article ''Nurses as leaders in chronic care''[3] in the British Medical Journal, in which he unequivocally asserts that: ''In some health systems, nurses are under-used, taking blood pressures and putting patients into rooms rather than providing education for and encouraging self management by chronically ill patients. Until these barriers are overcome, the potential for nurses to lead a national effort in the United States to improve chronic illness care may be thwarted''.

The countries with more flexible health policies and professional structures have looked to nurses as major players in the new care scenarios of this ''end of the disease era''. However, unfortunately for them, they lack sufficient ''stock'' of university graduate nurses and have had to create new roles (less qualified and more rapidly produced) to make up for these shortcomings. This is not the case in Spain, although the forces of conservatism, bureaucracy and elitism prevent us from seeing the wood for the trees in twenty-first century healthcare, and the new challenges that it poses.

The aim of this article is an attempt to summarise the reasons why, from an independent and purely intellectual perspective, I chose to cover these new approaches that place nurses as connectors and catalysts of the health services.

The demographic transition in Spain

The population in Spain increased by 14% between 2002 and 2017: but the population over the age of 75 increased by 50%, and over the age of 85 by 97%, according to the official data of the Spanish National Statistics Institute. We also have 1.9 million households where people over the age of 65 live alone, of whom only 35% receive any support from the National Dependency System; and almost 70% (1.3 million) of them are women. Regrettably, loneliness is an excellent predictor of functional decline and premature death.[4]

Statistically, women aged 65 outlive men by more than 4 years (23 years compared to 19); yet they only survive them by one year in good health (9 compared to 8) and spend the last 7 years of their lives in a situation of total dependency, compared to barely 4 years for men. The *demographic transition* in which we are immersed, therefore, affects women far more than men, constituting a clear *gender gap*.

But there is also an *economic gap*: poverty causes more premature deaths than obesity, alcohol abuse or high blood pressure.[5] As we are used to being reminded, a person's postal code has more impact on their health than their genetic code. Therefore we also have a *geographic gap*, since there are major differences between the peoples of Spain's different autonomous regions, especially in terms of level of income. Beyond our borders, a comprehensive European study of 15 countries[6] concluded that the rate of frailty in people over the age of 50 is highest in the countries with the lowest GDP per capita.

All these *gaps* tell us that health policies must target the segments of the population at greatest risk. And based on this, a study by the *Universitat Pompeu Fabra* concluded that the explosive cocktail of frailty is made up of three risk factors: female + low educational level + living alone[7]; almost a million people are in this situation.

Furthermore, in Spain the problems relating to long-term care (LTC) arising from the demographic transition will be more severe and intense than those of our surrounding countries, essentially for two reasons:

1. Our greater longevity: Spain is the European country with the highest life expectancy at birth (83.5 years of age compared to an EU-27 average of 81.0); the second country after France with the highest life expectancy, at both 65 (21.6 years) and 80 (9.6 years); and the third in the proportion of elderly people within the general population (Eurostat data, 2016).
2. Our dependency care model, essentially family and not institution-based; this is a model that from a cultural or social viewpoint might be desirable, but brings added complexities in the provision of LTC to dependent elderly people, especially because:

a) It relies on non-professional caregivers, which implies that requests for help with healthcare greatly risk being both excessive and insufficient and demanded of inappropriate areas (overuse of emergency services, particularly hospital departments).
b) It disseminates social and health care needs around the country, especially in the rural areas; it is not the same monitoring and providing care for 200 people within closed healthcare facilities as in their own homes.
c) In order to be sustainable, these models must be complemented with a proactive healthcare model in the community: beyond patient portfolios in home care programmes, with closed admission protocols basically centred on the care of medical diagnoses, professionals limit themselves to waiting for demands – or making them – closed in their clinic and without much control over adherence to treatments or planned consultations.
d) Finally, because coordination between the health and social services is generally insufficient and inadequate, with no combined decision-making care bodies deployed countrywide.

Primary and community care

Patients with multiple, chronic conditions are estimated to take up between 50% and 70% of health spending. There are 1.5 million frail and complex elderly people in Spain, comprising between 3% and 5% of the mean medical *quota* (1400): between 50 and 70 per general practitioner. This is a volume that it is impossible to cover under current conditions, since these are patients who require time-intensive and highly task-oriented care. Primary care doctors claim not to have the time they need to attend *acute* patients in minimal conditions of quality and safety. They are too taken up with healthy children's runny noses, and monitoring the platelet aggregation of otherwise healthy elderly people. At least until a real change is achieved, not merely rhetorical announcements, in primary care.

However, a nurse with advanced skills could take charge of the comprehensive care in the community of this *quota*, like the *community matrons* in Britain (a role also created in the British NHS in 2005). Not, of course, with the current primary care nurse staffing, but as a specific LTC programme, with its own funding.

In addition to the objective reasons, arising from the current dire organisation of primary care work – why exclude doctors as the backbone of care for patients with multiple disorders? – there are also subjective reasons.

Reproducing here the dramatic data on the choice of specialty of future medical residents, would be making an unnecessary *meal of things*; it is sufficient, therefore, to highlight some indisputable information: medical culture in Spain is far from community care oriented and this culture definitely has a demotivating effect among the doctors who choose — grudgingly — to practice in primary care. That is why, for example, pharmacies are offering to cover this flank, and this is something with which the three societies of primary care physicians have been senselessly collaborating.[8] It would be interesting to find out the real reasons.

The hospital

A few months ago, a British study[9] concluded — after a review of 1,013,590 clinical histories and following 22,139 discharges for 2 years — that frail patients already account for one in 5 hospital admissions and almost half of hospital stays. This results in growing saturation – during certain periods, outright collapse – of accident and emergency cubicles and hospital wards, principally due to the increased admission of these types of patients. Their inevitable correlate are extensive waiting lists that, if they already posed a serious management problem a few years ago are now an equally serious political problem given the understandable annoyance of millions of people with non-urgent (in principle) health problems who are not able to – or do not want to – take out private insurance.

Let's now take a visit to a hospital where a frail, decompensated patient is being admitted: when they have been diagnosed they are referred to the specialists in the organ that has caused this specific episode, and they are admitted to the relevant unit. In this ward, excessive patient nurse ratios, the need to give priority to medical orders and assuming a wide range of activities that, although not nursing tasks, are *taken for granted*,[10] result in a failure to comply with an appropriate care plan for our patient, if one even exists. And in addition to more complex nursing activities, such as diagnoses of needs, recording interventions or discharge reports, certain basic or essential nursing care is not being provided,[11] often with serious consequences for the patient.

Firstly, because for these frail people impeccable basic care is every bit as important as receiving appropriate medical treatment: sleep, nutrition, hydration, hygiene, mobilisation, socialisation, etc. And also because these inappropriate ratios are a direct cause of iatrogenesis and adverse effects, of longer hospital stays and more frequent rehospitalisation; the rates of in-hospital mortality even increase. This is well known through the studies that Linda Aiken has spent almost 20 years leading in different contexts and countries, including Spain. Inadequate – in both quantity and quality – staffing (nurses) causes suffering, increased care costs and burnout of professionals.

Therefore it is essential to have hospital units that specialise in the care of frail and complex patients. Attended medically by geriatricians – or internists –, but organised, directed and managed by specialist nurses (note, I did not write ''specialist female''). Not only do they provide comprehensive care that prevent physical, cognitive and social decline as far as is possible, but they help to avoid adverse effects, preventable rehospitalisation and premature deaths. There has already been some experience in our country, which should be assessed to discover their real level of success in terms of health and cost outcomes. In complex systems, common sense can sometimes turn against us.

Coordination between levels

Although culturally the focus of *advanced practice* has tended to be in decisive community nursing and hypertechnified hospital nursing, the changes taking place in hospitals will make advanced practice necessary in the care of hospitalised chronic and complex patients. But, above all, strict coordination between both care levels will be essential, with a common aim of caring for people in the community, reducing avoidable hospitalisation to the extent possible, and returning them to the community with the least possible deterioration in their condition, should they require urgent care or have to be hospitalised.

However important, and it undoubtedly is, and however much the emphasis is placed on the relationship between internists and general practitioners in improving coordination between both levels, nurses, not doctors, are the best-prepared professionals, in terms of both culture and training, to ensure continuity of care. As the British magazine *The Economist*[12] put it several years ago: ''to treat the 21st century's problems with a 20th-century approach to health care would require an impossible number of doctors. For another, caring for chronic conditions is not what doctors are best at. For both these reasons doctors look set to

become much less central to health care—a process which, in some places, has already started.''

Are nurses ready to cross ''through the looking glass''?

The Spanish health services should commit to advanced competences for nurses for one simple reason: because their life depends on it, literally. But only if they are capable of changing their entrenched doctor-hospital-centred culture to a different culture that guides them through the cold areas (large resources, few results) to the warm areas (few resources, large yields),[13] will our health services be able to weather the demographic storm that is approaching us. Because it will soon be the baby-boomers, and not our parents, who need nurses with advanced skills who are able to cross ''through the looking glass''.

However, nurses must make a firm commitment to improvement. Starting with a change of some of their ''leaders'' who dwell on twentieth century perspectives and discourse and are unable to *create a narrative* and communicate it inside and outside the profession. Followed by association and management structures (mesocracy), that must also make an effort to cooperate, instead of each going their own way, claiming their place at the table. And ending up in demobilised professional bases lacking cohesion, bereft of clinical leadership, retreating *to their comfort zones*, as attempting to pass unnoticed is termed nowadays.

Political and health service managers must decide, after cold analysis of the situation, whether they prefer the army of the *walking dead* (with a head — to manage scarce resources — but with no brain – to innovate and lead care —) that they have had to date, or professionalised and autonomous human resources in a continuous process of improvement and taking on new responsibilities.

Judging from what I hear at the numerous nursing events to which I have been fortunate enough to be invited, many nurses believe that motivation and professionalism have declined somewhat, largely due to working and employment conditions that have taken them to the edge. Although it seems that some of the most harmful measures are now being reversed (job insecurity, replacement rates, etc.) and employment is being regenerated, some disastrous staffing policies, directed from the Ministry of Finance, but crudely delivered through the health services, have created a cohort of professionals lacking properly defined professional benchmarks or values.

Condemned to wandering through the units like lost souls (3 days in accident and emergency, 2 weeks in neonatal, 3 months in a health centre, temporary work in extractions, in a mental health centre, etc.), with no clinical mentoring or leadership, not having been able to learn the key elements of nursing professionalism, and this, we have found through surveys, leads to dangerous nihilism, especially since these nurses are the future of the profession.

Faced with this situation it is appropriate to remember that things started more or less like this in the English NHS hospital of Stafford that experienced a terrible decline in nursing care (they termed it ''compassion crisis''), which resulted in allegations of abuse, neglect of duties, neglect of patients and hundreds of avoidable deaths attributable to poor nursing practice. A disaster that took 5 years to detect and many more to redress,[14] largely due to the prevailing ''culture of silence''.

This situation was resolved by policy making at all levels: macro (health regulation and policies), meso (management and associationism) and micro (professional teams). But everyone would need to be asked (in this order): do you want to? Do you know? Are you able to?

Since the publication in 2010 of 'Nursing in front of the mirror: myths and realities',[15] the nursing profession has worked on analysing their myths and realities and it is now time to ask whether it is in a better position to stop gazing into the looking glass and, like Alice, cross through.

Conflict of interests

The author has no conflict of interests to declare.

References

1. Cesari M, Marzetti E, Thiem U, Pérez-Zepeda MU, Abellan Van Kan G, Landi F, et al. The geriatric management of frailty as paradigm of ''The end of the disease era''. Eur J Intern Med. 2016;31:11–4.
2. Rockwood K. An unsuitable old age: the paradoxes of elder care. CMAJ. 2005;173:1501–2.
3. Bodenheimer T, McGregor K. Nurses as leaders in chronic care. BMJ. 2005;330:612–61.
4. Perissinotto CM, Stijacic Cenzer I, Covinsky KE. Loneliness in older persons: a predictor of functional decline and death. Arch Intern Med. 2012;172:1078–83.
5. Stringhini S, Carmeli C, Jokela M, Avendaño M, Muennig P, Guida F, et al. Socioeconomic status and the 25 × 25 risk factors as determinants of premature mortality: a multicohort study and meta-analysis of 1.7 million men and women. Lancet. 2017;389:1229–37.
6. Theou O, Brothers TD, Rockwood MR, Haardt D, Mitnitski A, Rockwood K. Exploring the relationship between national economic indicators and relative fitness and frailty in middle-aged and older Europeans. Age Age. 2013;42:614–9.
7. Gumà J, Arpino B, Solé-Auró A. Determinantes sociales de la salud de distintos niveles por género: educación y hogar en España. Gac Sanit. 2017, http://dx.doi.org/10.1016/j.gaceta.2017.11.010 [in press].
8. SEFAC, SEMERGEN, semFYC y SEMG. Modelo de coordinación médico-farmacéutico para la atención al paciente con enfermedad crónica en atención primaria; 2017 [accessed 25 Jun 2018]. Available from: https://www.sefac.org/sites/default/files/2017-11/Coordinacion_Medico_farmaceutico_cronicos.pdf
9. Gilbert T, Neuburger J, Kraindel J, Keeble E, Smith P, Ariti C, et al. Development and validation of a Hospital Frailty Risk Score focusing on older people in acute care settings using electronic hospital records: an observational study. Lancet. 2018;391:1775–82.
10. Ross C, Rogers C, King C. Safety culture and an invisible nursing workload. Collegian. 2018, http://dx.doi.org/10.1016/j.colegn.2018.02.002 [in press].
11. Ball JE, Bruyneel L, Aiken LH, Sermeus W, Sloane DM, Rafferty AM, et al. Post-operative mortality, missed care and nurse

staffing in nine countries: a cross-sectional study. Int J Nurs Stud. 2018;78:10–5.
12. The future of medicine. Squeezing out the doctor. The role of physicians at the centre of health care is under pressure. The Economist. 2 de junio de 2012. Available from: https://www.economist.com/briefing/2012/06/02/squeezing-out-the-doctor [accessed 25.06.18].
13. Varela J. Los pacientes crónicos complejos y la estrategia del océano azul. Avances en Gestión Clínica [Blog]. 25 de enero de 2016 [accessed 25 Jun 2018]. Available from: http://gestionclinicavarela.blogspot.com.es/2016/01/los-pacientes-cronicos-complejos-y-la.html
14. Acceso a la información e informes [accessed 25 Jun 2018]. Available from: http://www.midstaffspublicinquiry.com/
15. Hernández-Yáñez JF. La enfermería frente al espejo: mitos y realidades. Madrid: Fundación Alternativas; 2010.