

Title: 'Prioritise people': the contribution of anti-oppressive practice

Applicants for pre-registration nurse programmes undergo 'Values-based recruitment' (VBR) selection procedures (HEE 2014), in part as a consequence of the Francis Inquiry (Francis 2013), which highlighted concerns about recruiting people with the right values into nursing. Some of us 'old hands' in nurse education may dispute this logic, but none the less an increased focus on recruitment processes, not least a greater valuing of the involvement of service users has made the process more rounded, as academic criteria and attitudes showing commitment to empathetic, humanised care are judged as equally important in selection procedures.

Clearly however VBR is not a panacea to right all the wrongs uncovered by Francis. There could be 'one bad apple spoiling the barrel' but experience indicates that most nurses are in the profession for the right reasons. However the strengthening of our revised professional Code (NMC 2015: 4) to more clearly reflect the prime importance of humanised care, has been welcomed. The first section captures this very succinctly: 'Prioritise people': (...) 'put the interests of people using or needing nursing or midwifery services first' [and] 'make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.'

So together with the implementation of the national strategy for nurses and midwives in England (NHS 2012) and similar documents in other UK countries, as well as a raft of other supportive initiatives, it might be assumed that dehumanised care is a thing of the past. Its increased focus clearly helps give permission for nurses to prioritise people first in the real-life context of other competing priorities, such as complying with the four-hour Emergency Department (ED) waiting time target. This target one of many NHS performance metrics (Mason et al. 2012) and given organisational pressures to meet these targets with the associated financial penalties, it is easy to imagine that care could become very task driven to avoid breaching the target. Many nurse students feel excited about working in ED, but quickly perceive the tension amongst colleagues to ensure 'breaching' is avoided, a cultural feature that is likely to impact on their practice. This does not mean however that ED nurses have the 'wrong' values; quite the contrary, staff probably feel frustrated that 'the system' impacts in this way on the way they want to care.

Having the right values therefore is not the whole story to ensuring people is our first priority. To understand why less than optimum practice may be perpetuated, it is useful to consider the concept of oppressive practice. Oppression as the devaluing of people in terms of who they are and what they offer (Thompson 2011). This can lead to discrimination and the degrading treatment of individuals or groups, injustice and the abuse of power. Oppression can be understood at three interacting levels: personal, cultural and structural. The structural level relates to factors in society and organisations that impact on the distribution of resources and power. So for example in the ED scenario, the NHS has finite resources; national policy controls spending through the imposition of targets and local organisations put the necessary processes in place to comply. One can imagine that the nurse 'on the ground' aims to provide efficient, effective and humanised care, but is aware of the imperative to prevent breaching the waiting time target. Despite good intentions when the pressure is on, getting tasks completed and the patient out of the system may become the priority, perhaps compromising humanly sensitive care.

Our professional code however should ensure care is not dehumanised regardless of structural pressures. This links to the cultural level of oppression (Thompson, 2011); if nursing and departmental teams have a shared understanding of the primacy of putting the person and not the system first, then that culture will not support oppressive practice. However whilst strongly advocated, sometimes routines and practices reveal the contrary; for example interrupting an assessment so a nurse can move someone out of the department who is 'about to breach', gives a message as to what counts. If that person is someone, perhaps with mental health issues who repeatedly presents at ED, it might mean staff feel less guilty about the interruption. This highlights the final level of oppression, the personal level where our personal prejudices (and we all have them) may in busy times influence care priorities.

Fortunately the support for anti-oppressive practice is stronger than ever. Health care staff are encouraged to challenge discrimination and oppression, both against patients and other staff and the moral, legal and professional mechanisms to support this are stronger than ever. We do need to accept however that we too are only human, capable of prejudice and oppression, albeit unintentional in most cases. It is simplistic perhaps to imagine that policy and guidance can ensure person-centred care. This comes from within: it needs to be part of our being and when challenged we need sufficient insight to recognise our part in making things better, in terms of non-judgmental practice and challenging cultural norms or unreasonable policy imperatives.

References

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Dr Janet Scammell, Associate Professor (Nursing), Bournemouth University